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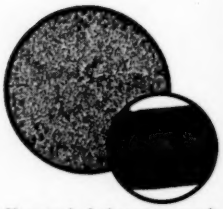

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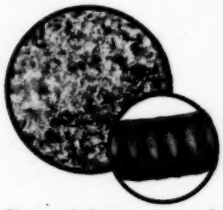

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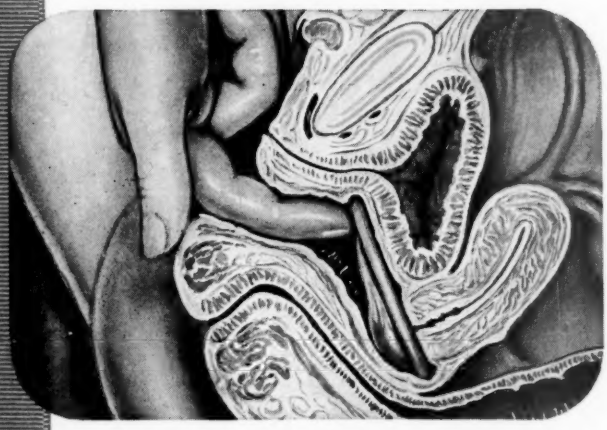

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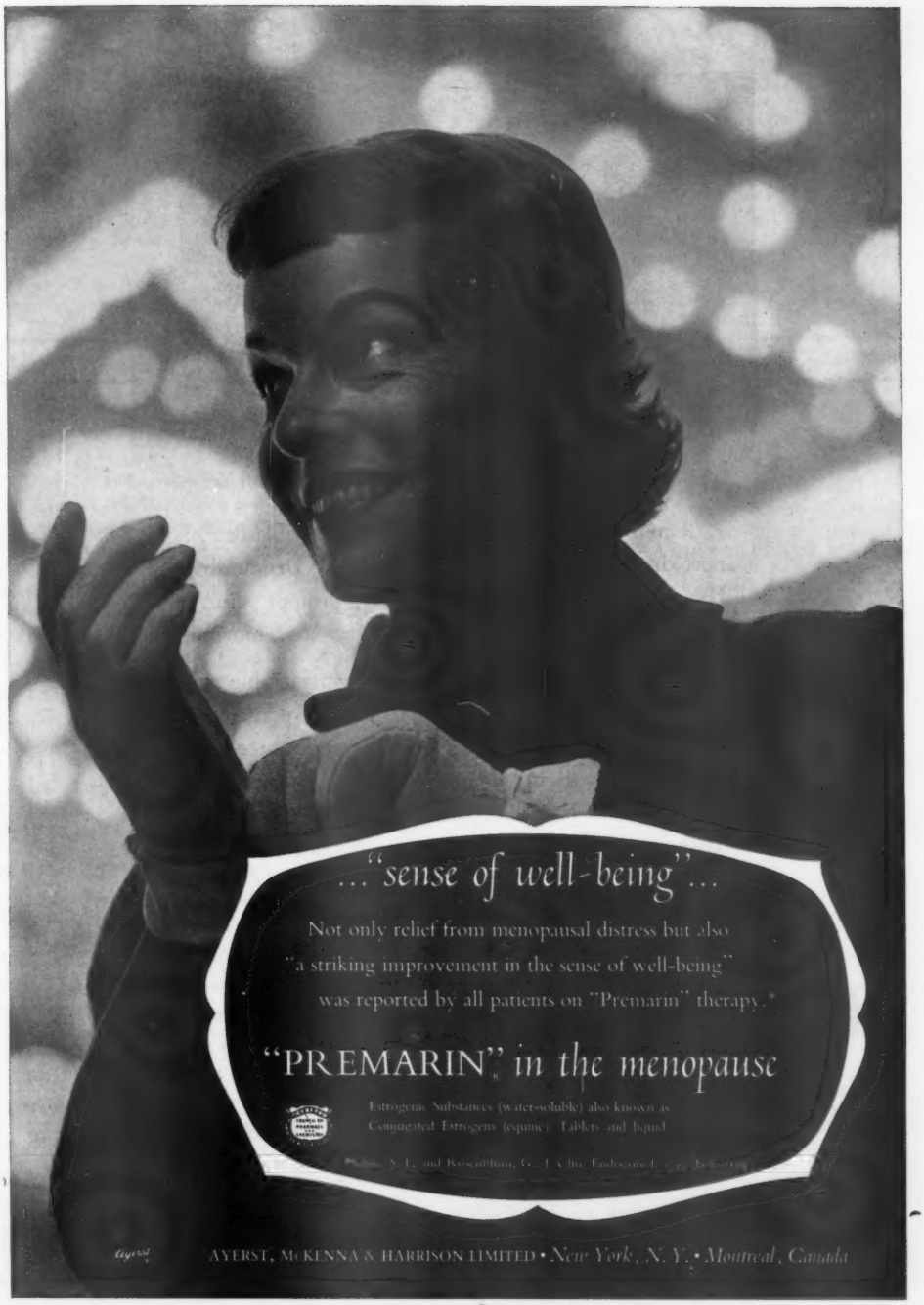
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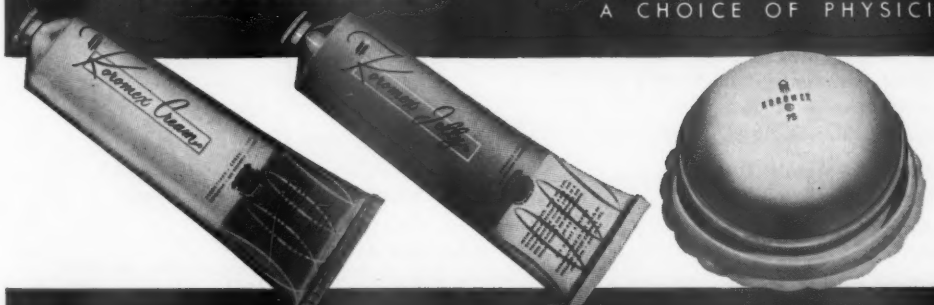

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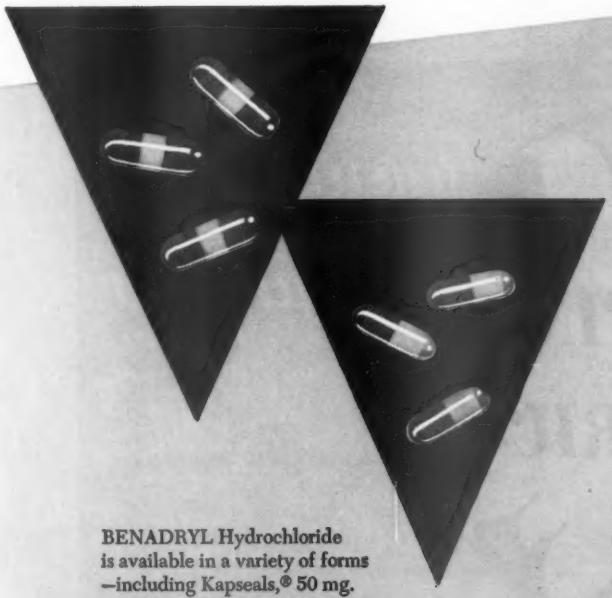

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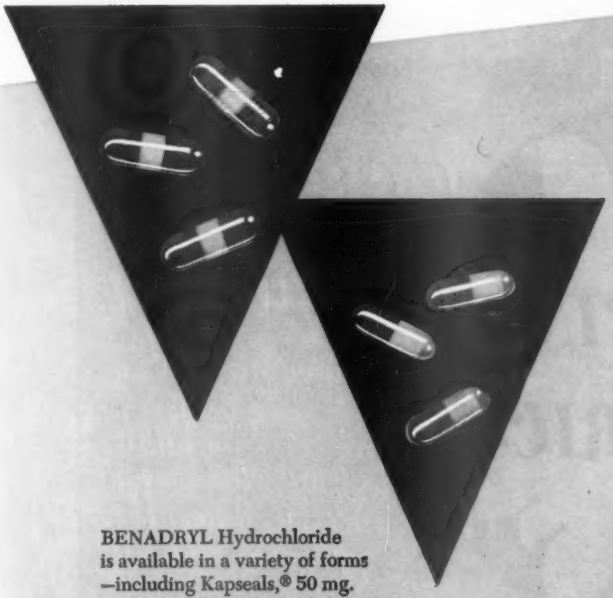

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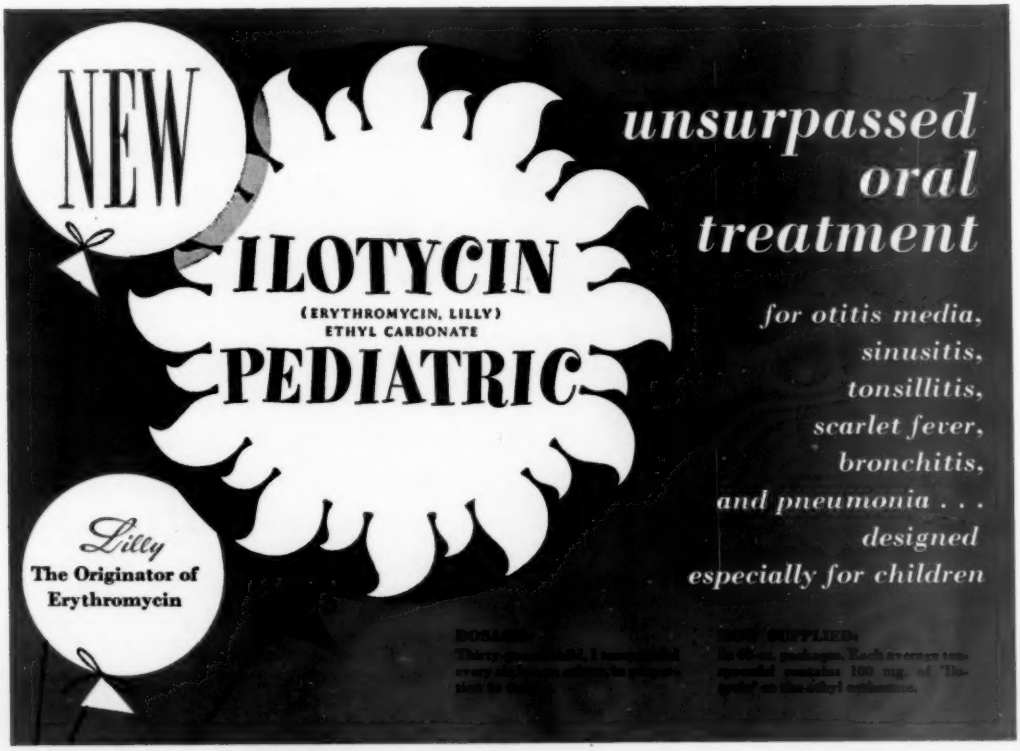

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WHO and Afghanistan

R. L. Tuli, M.D.

WHO HAS BEEN ASSISTING the government of Afghanistan in various ways since 1949; as a first step, a survey was made of the malaria problem in the country. Since then, WHO projects in the country have multiplied and a WHO Public Health Adviser is now assisting the Afghan government in devising a long-term plan of public health development into which the existing projects will be integrated. Thus, the pattern of WHO assistance to Afghanistan furnishes a good example of the way in which WHO is carrying out its fundamental task.

Afghanistan, or the land of the Afghans, is a sovereign, democratic, and constitutional monarchy. There is a cabinet presided over by the Prime Minister elected by the members of Parliament on approval of the King. The Prime Minister and his cabinet administer the country with the help of the High Council of State, composed of seven members headed by the Prime Minister, which is the supreme administrative body.

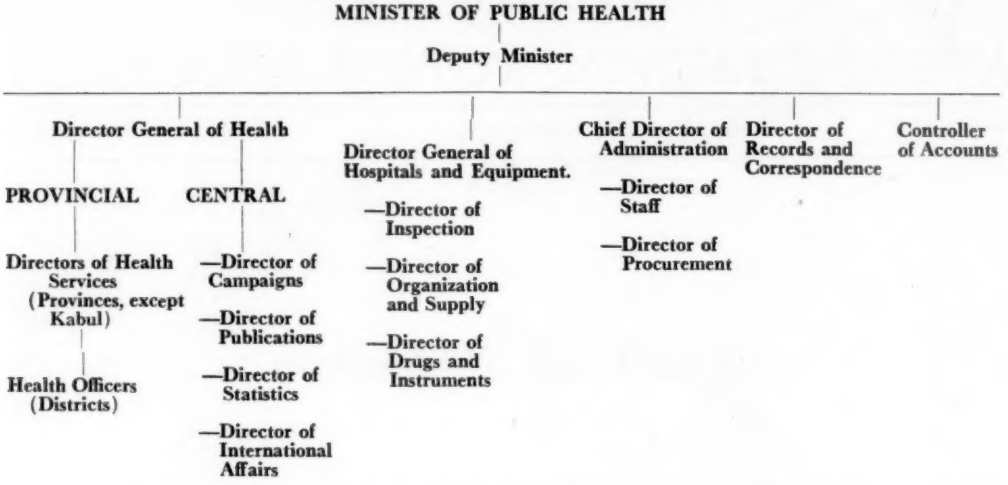
The country is divided into 10 provinces: Kabul, Kandahar, Herat, Mazar, Kataghan, Eastern Province, Southern Province, Maimanah, Farah, and Badakhshan, for each of which there is a governor under the Ministry of the Interior to conduct the administration. The country covers 247,000 square miles and has a population of approximately 13 million (12 million in the United Nations Demographic Year Book, 1949). Afghanistan is a hilly country, a great part of which consists of snow covered mountains, 20,000 to 25,000 feet high. There is no outlet to the open sea and most of the rivers, after rushing down the mountain slopes, dwindle into small streams which are either absorbed inland or by the neighbouring countries.

Regarding climatic conditions, it is 10 to 20 degrees centigrade below zero in certain parts of the country during January and February with snow on the ground for about four months. During summer (May to July) the highest temperature recorded is 99 degrees Fahrenheit. The months from January to April constitute the rainy season, but the annual rainfall in Kabul is usually not more than 15 inches.

Dr. Tuli was Director of Public Health in the Central Provinces of India before joining the WHO as Public Health Officer. He is now WHO Representative in Ceylon.

TABLE I

Public Health Organization of Afghanistan



Public Health Organization

The medical and public health work in Afghanistan is under the direction of the Ministry of Public Health (Table I). The Minister and the Deputy Minister of Public Health supervise the work of five different departments and divisions in the Ministry. There are two separate departments of health and medical services, namely, the Department of Health and the Department of Hospitals and Equipment. The administration is centralized both in power and responsibility at the top level, resulting in less authority for the Director General of Health Services as well as for the Director General of Hospitals (or Medical Services).

Each province, except Kabul, has a director of Health Services, who is responsible to the Ministry for the general routine medical and health work of the province. The health and medical work in the province of Kabul rests with the Health Ministry.

WHO in November 1951 assigned a Public Health Adviser to assist the government in its long-term planning in regard to its medical or paramedical training, the reorganization of its public health programme, and integration of existing short-term projects into the national health plans taking local conditions into consideration.

During 1952, the following was achieved:

1. The method of survey of medical and public health conditions was discussed with the health authorities, and forms for it were approved by the Ministry. It is expected that the findings of the survey will provide the Ministry with reliable data on which to base their future plans for the improvement of health conditions.
2. The reorganization of the central organization of the Ministry of Health was discussed and necessary proposals were made.
3. Suggestions were made for the proper maintenance of requisite records needed for international work and for the collection and study of hospital statistics.

The adviser assisted in stimulating a request from the government for the establishment of a community project in the vicinity of Kabul, which is expected to be a joint project between the government and the United Nations specialized agencies operating in Afghanistan. This area is expected to be used as a field training area for medical and paramedical students. The government has provided an understudy to work with the public health adviser and has also provided him with free lodging, transportation, and office accommodation.

In 1953, provision has been made for the continuation of the services of the public health adviser, under the WHO Technical Assistance budget. Proposal has been made to provide one international fellowship of 12 months' duration in public health administration.

It is expected that by the end of 1953, plans will have been formulated to improve the health services of the country, to initiate the community centre, to train some key personnel, and to prepare plans for subsequent development.

In 1954, it will be proposed that the services of the adviser be continued under the WHO Technical Assistance budget to assist the government in the further development of its health services, and also to see that proper co-ordination is maintained in respect to the different health programmes initiated or undertaken by different agencies in the country. It is expected that, by the end of 1954, a suitably trained national will be available to take over from the public health adviser.

Malaria

Owing to the lack of a system for registration of births and deaths in the country and also because of the limited information which can be obtained about morbidity statistics from the few dispensaries, it is difficult to gauge precisely the actual morbidity from malaria, but there is no doubt that it is a great obstacle to the economic development of the country. During May to July 1949, the WHO Regional Office for Southeast Asia sent a malaria specialist to survey the malaria incidence over the entire country. The malaria expert visited about 40 different places and examined over 3,000 children under 10 years of age. His findings revealed a high incidence of malaria in the country. The object of this survey was also to select a hyperendemic area for a malaria control demonstration.

Malaria is found in almost all parts of Afghanistan in more or less hyperendemic and endemic forms and is a serious public health problem. It is widespread in the fertile valleys and in other parts, affecting the people at a time when they are most needed for agricultural activities—sowing season or harvesting time. The government realized the seriousness of the disease but could not do much owing to the paucity of trained personnel and equipment. The antimalaria organization of the government was started in 1948.

In July 1949, the WHO Regional Office sent a team consisting of a leader, a malaria specialist, and a senior malaria inspector to start a pilot malaria control demonstration project in Laghman valley, one of the chief rice producing areas—population approximately 14,000. The DDT residual spraying operation from July to October 1949 caused a dramatic reduction in the incidence of the disease. *A. superpictus* and *A. culicifacies* were incriminated as the notorious carriers of the disease. The season of transmission is believed to extend from May to October. The epidemic is of a very low grade from May to June and very intensive from July to October. A very high degree of transmission was noticed, resulting in an infant parasite rate of 70 percent. The pilot demonstration team operated with DDT indoor residual spraying, which resulted in a remarkable reduction of infant parasite rates and in the incidence of the disease.

During June to October 1950, a full scale WHO malaria control demonstration team, consisting of an entomologist as the leader, a public health engineer, a malariologist, and a senior malaria inspector, operated in an area of 175 square miles which had an approximate population of 45,000 (Kunduz and Khanabad). This is a remote part of Afghanistan, bordering on Soviet Russia and Turkistan, and is reached after 24 hours of travel from Kabul by motor car on rough roads. The DDT indoor residual spraying

TABLE II

Spleen and Parasite Surveys in Kunduz

	Demonstration Area	Check Area
SPLEEN RATES		
Preoperational period, 1950	40.2%	46.7%
Postoperational period, 1950	36.1	51.2
Preoperational survey, 1951	37.8	52.2
Postoperational 1951—sprayed in both 1950 and 1951	15.4	
Postoperational 1951—sprayed only in 1951	22.2	58.8
PARASITE RATES		
Preoperational, 1950	8.9	8.9
Postoperational, 1950	5.0	13.0
Preoperational, 1951	2.2	8.05
Postoperational 1951—area sprayed in 1950 and 1951	0.8	
Postoperational 1951—area sprayed in 1951 only	1.9	11.4

produced highly satisfactory results, and the malaria morbidity became practically negligible.

In 1951, the WHO full scale malaria control demonstration project was continued. The operations were resumed and performed from May to November 1951. The area was extended to over 820 square miles in Kunduz and Khanabad districts. It included about 148,000 people. Malaria morbidity in the sprayed villages had been practically negligible. A comparative statement of the malariometric indices, preoperational and postoperational, in the demonstration and check areas is given (Table II).

The infant parasite rate was nil at the end of two years in the demonstration area, whereas it was 15.2 percent in the check area. There was no malaria morbidity in the sprayed villages.

In 1952, the antimalaria operations were continued including an approximate population of 685,000 in 12 different districts of the country, including Kabul city and the areas operated during 1951. Under WHO's regular budget, provision was made for a malariologist for a period of 12 months and an entomologist for 4 months, with equipment and supplies. This team, with the part-time services of the public health engineer, undertook a study of malaria incidence in Kabul. It also assisted the government in launching large-scale antimalarial operations in the capital of the country. UNICEF has also assisted with a substantial amount (16 tons) of DDT as a matching contribution on the basis of one ton per every ton of DDT purchased and used by the government, over and above their previous year's consumption of the insecticide. WHO also helped in the organization of a malaria institute at Kabul, which will serve as a research and training centre for the national staff. The WHO experts will also assist the government in appraising the results of the operations.

The government has undertaken to provide the necessary matching personnel and ancillary staff, accommodation for international personnel, stores, laboratory, and transport, as well as supplementary equipment and supplies, labour squads, and other necessary facilities. It has also made the necessary budgetary provision. It is expected that the work will be integrated into the national health service.

In 1953, to assist the government in the planning and further expansion of malaria control, as well as to develop the Malaria Institute at Kabul on proper lines, a malaria specialist has been assigned for the year. It is hoped that the specialist will be able to undertake surveys in areas yet unexplored, particularly such areas as are different physiogeographically from those in which demonstrations have already been held. With a view to strengthen the malaria organization and accelerate the planned programme of malaria control, three regional fellowships are to be awarded this year under the regular budget of WHO; one in malariology and two in entomology.

By the beginning of 1954, it is anticipated that protection against malaria will be extended to most of the areas where epidemiologic conditions are not dissimilar to those of Kunduz, where the WHO team demonstrated control methods in 1950 and 1951. It is also anticipated that the malaria organization will be sufficiently strengthened to cope with demands of an expanded programme and that the Malaria Institute will be fairly well organized. However, the problem of malaria in areas with differing epidemiologic conditions will remain to be dealt with. Before the goal of complete freedom from malaria can be reached, further investigations will have to be conducted to explore possibilities of reduction in the cost of malaria control to make it feasible within the economy of the country. With these ends in view, it is proposed to provide in our budget for 1954, an international malaria team consisting of: one malariologist, one entomologist, and one malaria inspector, with equipment and supplies (up to an amount of $25,000) provided by the government through bilateral assistance. The Organization will provide an amount of $5,000 as contingent expenditure. This programme for 1954 is proposed to be met from Technical Assistance funds. From the same funds, it is also proposed to provide a regional fellowship in malariology for five months.

Typhus

Epidemic typhus is among the most important of the communicable diseases which, each year, afflict several provinces of Afghanistan, especially those of Kandahar and Kabul. This is indicated by official and hospital records and by local enquiries. A particularly severe epidemic of the disease was recorded in the winter of 1947-1948. Data, which were incomplete, show that, in Kandahar province alone, there were 969 cases. The mortality rate was believed to be unusually high, probably because of the paucity of hospital facilities for communicable diseases in affected areas.

The disease assumes epidemic proportions about midwinter in both Kabul and Kandahar provinces. The peak of transmission appears to occur somewhat earlier at Kabul which, at an elevation of nearly 6,000 feet above sea level, is first struck by winter's cold waves descending on the country from the north. By the end of February, the epidemic

usually begins to subside, and near the end of March reverts to an endemic status.

Typhus statistics are not reliable. The only information available is from the dispensary figures. The medical officer reports cases which come to his knowledge. Cases are reported during winter months from almost the entire country. Local enquiries reveal that more than one case occurs in one family. The low economic status of a large segment of the population and the overcrowded living conditions during the winter months aid greatly in the spread of the disease.

WHO became interested in this work on receiving a disquieting report with regard to the high incidence of epidemic typhus in Afghanistan in 1949. The Government of Afghanistan requested a supply of typhus vaccine to combat the disease. The WHO Regional Office made arrangements for the supply of the vaccine and, at the same time, deputed a medical officer to investigate the situation with a view ultimately to propose typhus control measures in the country. The medical officer drew up a comprehensive plan of action and actually initiated the training of nationals to undertake large-scale delousing operations with an aim to protect the population from this disease. Subsequently, special WHO personnel, a sanitarian to begin with and a medical officer later, were assigned to assist the government in carrying out the control measures.

During the winter months of 1950-1951, when the WHO international personnel engaged in antimalarial operations were comparatively free, they were utilized to organize and carry on an antityphus campaign in the two main cities, Kabul and Kandahar. In these two cities, the total number of people deloused was 195,856 and the total number of pieces of clothes, blankets, carpets, and so forth dusted was 1,687,430. In Kandahar alone, which is the smaller town of the two, a total number of 66,119 people (including 17,633 women) was deloused. The most remarkable feature of the entire campaign in Kabul and Kandahar was the successful DDT treatment of a large number of women in purdah by the female disinfectors employed for the purpose. Among the total number of 195,856 people who were dusted with DDT powder, there were 45,962 women.

Chief reliance for the prevention of typhus was placed on systematic delousing operations with 10 percent DDT powder. All individuals, along with their bedding and dustable clothing, were deloused during house to house visits. The use of antityphus vaccine was restricted to special circumstances, where actual contacts with the disease required protection. The result of the operation was that not a single case of typhus fever occurred in the protected population of Kandahar, and only five cases in Kabul, of which two were imported.

TABLE III

Typhus Disease Cases in Afghanistan by Months*

Year	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
1949	72	141	1,197	78	126	82	71	14	8	5	20	21	1,835
1950	67	203	254	405	248	105	10	5	2	4	5	23	1,331
1951	90	30	49	111	106	110	72	43	24	17	20	45	717
1952	28	48	28	70	42	34	8						

Typhus Disease Cases in Kabul by Months*

Year	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
1949	8	37	26	20	77	30	16	9	6	1	19	6	225
1950	21	34	30	66	87	21	6	3	2	2	2	4	278
1951	11	8	15	57	89	102	70	39	18	16	17	34	476
1952	18	20	9	25	10	10							

TABLE IV

Typhus Disease Cases in Kandahar by Months*

Year	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
1949	16	46	907	19	16	26	18	—	1	4	—	12	1,065
1950	11	151	95	307	121	68	3	—	—	—	—	7	763
1951	19	4	10	10	1	—	—	—	—	1	—	—	49
1952	4	—	3	2	13	1							

*As reported by the Singapore Epidemiologic Intelligence Station and the Ministry of Health.

Antityphus DDT operations for 1951 to 1952, which started on December 31, 1951, covered part of Kabul, Kandahar, and other provinces. These operations which were carried out on the same pattern as those of the previous year, were, from the start, on a much larger scale. A population of 312,832, including military and police personnel operating in and around the cities of Kabul and Kandahar, was dusted. It also included 81,312 women in purdah who were successfully treated by the female disinfectors working with the antityphus squads. In addition, an estimated 70,000 inhabitants were protected in other centres and provinces. Field operations came to a close on February 29, 1952, in the Kabul area, and on March 12 in Kandahar province.

As a result of 1951 and 1952 operations, not a single case of louse-borne typhus fever occurred in the city of Kandahar and only four cases were recorded in the city of Kabul, in spite of the late start of the field operations in this area. The disease could not get a foothold in the treated communities. The control measures cost 0.60 Afghani (three cents) per head. The measures undertaken gave the anticipated results and were economical and well within the means of the community.

The operations met with universal approval and the success achieved caught the imagination of the people, with the result that a large number of applications and petitions were received by the government to extend the operations to other portions of the country. The government showed keen interest and, appreciating the situation, undertook to launch large-scale antityphus control measures. To carry on the programme in future years, 172 Afghan workers are being trained. The services of the public health engineer and those of the malariologist are available to the government for this purpose. UNICEF also became interested in the problem and agreed to assist in the efforts of WHO and the government to combat this disease, by supplying DDT formulation and dust guns along with pulverizer and a mixer. Statistics of typhus during 1949 to 1952 are shown (Tables III and IV).

Tuberculosis

There are no reliable data available with regard to tuberculosis morbidity and mortality rates in Afghanistan. Except for limited outpatient activities associated with the TB hopitals in Kabul, there were no other clinical or dispensary activities in the country. There is a small TB hospital at Kabul for female patients, with a preventorium section for children, and about 50 beds are available for male patients at the Medical Faculty Hospital in Kabul. The country seemed to be virgin soil as far as the formation of a TB service is concerned. It offered a good field for the establishment of a WHO Demonstration and Training Centre. In preparation for an activity of this kind, advantage was taken by the Afghan government of fellowships offered in TB control and in radiology during 1951 and 1952.

In 1952, provision was made under the WHO Technical Assistance budget for an international team consisting of: one senior adviser, one nurse, one x-ray technician, and one laboratory technician, with equipment and supplies. This Demonstration and Training Centre was established in Kabul and it is expected that it will function until the end of 1954.

The government provides suitable accommodation for the clinic: the services of a part-time local bacteriologist, and 10 other local personnel, together with such supplies as are required for the project and can be produced within the country. It also provides the international staff with free medical assistance, transportation, and accommodation. It is expected that the programme will ultimately be integrated with the national health service of the country.

Tuberculosis is a disease which has great bearing on the economic conditions of the people, as it strikes the individual at the most productive period of his life. The control of this disease will conserve manpower and raise the standard of living.

In 1953, provision was made for the continuation of the international staff of 1952, with the addition of an international BCG nurse. This was in the belief that Afghanistan could not yet absorb the standard type of BCG project, envisaging development into a mass vaccination campaign, but that the association of BCG vaccination with the general TB project would be advisable. It is proposed also to supply a mobile x-ray unit for the use of which personnel were trained in 1952 on a static, mass radiography machine.

It is proposed to provide one regional fellowship of 12 months' duration to enable a medical officer, who has received preliminary training at the Demonstration and Training Centre, to study in India.

In 1954, it is proposed to continue the international staff as in 1953 along with the requisite equipment and supplies. Toward the end of the year, the Demonstration and Training Centre at Kabul will be given over to the matching native personnel for operation.

It is anticipated that, by the end of 1954, at least six doctors, six or eight nurses, six x-ray technicians and darkroom attendants, and three or four laboratory technicians will be trained, and that a TB service will be in operation in Kabul. The nature of the

Figure 1.

Figure 2.

Figure 3.

Figure 4.

Fig. 1. Typhus. Members of an Afghan Government Team treating the bedding in houses. Fig. 2. Part of the work of the Malaria Control Demonstration Team in Kunduz-Khanabad, N. Afghanistan. Drops of blood are collected from village children for examination in the team's laboratory. Fig. 3. Maternal and Child Health. A woman member of the WHO team, Dr. V. Leymus of Finland, and an Afghan medical man, Dr. Lizmuddin, working in the WHO clinic in Kabul. Fig. 4. Dr. J. C. Cutler (USA), a WHO consultant in venereal diseases (left), examining two children during a survey of the VD situation in Afghanistan.

TB problem facing the government will be made clear by mass radiography and tuberculin surveys of various population groups.

Joint Venereal Disease Control and Maternal and Child Health Programme

The Government of Afghanistan has been interested in maternal and child care for some time. A separate body has been working with the support of the Ministry of Health and the Municipality of Kabul. This led to the foundation in 1947 of the Rozantoon Society, the government sponsored organization for the care of mothers, infants, and children. The Board of the Society is presided over by a paediatrician, and comprises medical representatives from the Ministry of Health, the Ministry of Education, the Faculty of Medicine, and the Municipal Council of Kabul.

As statistics regarding population, births, deaths, infant or neonatal deaths were meager, the maternal and child health problems had to be assessed from the WHO Regional Director's personal observations and from the surveys conducted separately by venereal disease and malaria experts, sent by the WHO Regional Office during May and July 1949. One thing was quite clear from these observations, namely, that the country was badly in need of assistance in the field of maternal and child care and in antivenereal disease activities.

It was estimated that about 20 to 40 percent of infants and children died before they attained maturity. The suspected major causes of infant and child deaths were malaria, bowel diseases, tuberculosis, venereal diseases, ascariasis, malnutrition, and respiratory diseases. The diet was unbalanced and very low in protein. General sanitary conditions were bad; drinking water was polluted (in one instance sewage was drained into the drinking water canal), faeces and urine were deposited outside the houses and exposed to swarms of flies. Maternity care was poor because of the strict custom of purdah and lack of trained personnel. The prevalence of gynaecologic and venereal diseases was a serious problem. Sterility and abortions were common and only a small proportion of pregnancies resulted in the birth of a healthy child. During the survey of the WHO venereal disease expert, it was learned that one woman of about 55 years of age had had twenty pregnancies without a single surviving child. The maternal death rate and the principal causes of maternal deaths were unknown.

At the request of the Afghan government, a WHO/UNICEF pilot project on MCH/VD started in August 1950, with the initial object of undertaking a study of the problem in Kabul, and then, in the light of the findings, to develop a comprehensive plan to institute services to mothers and children in Afghanistan. The team, consisting of a serologist, a paediatrician, and a public health nurse-midwife, was assigned to survey the diseases prevalent among children, infants, and nursing and expectant mothers, and to produce a proper plan for development of MCH and anti-VD activities. VD work was added to the programme because of the crippling effect of extensive congenital syphilis. The experts were also assigned to establish a confinement service, to teach paediatric nursing and midwifery, to provide antibiotics, sulfonamides, vitamin preparations, and supplementary foods, to start a public health diagnostic laboratory service initially with serologic diagnostic work, and to obtain an estimate of the incidence of syphilis in different parts of the country. The pilot MCH/VD project was begun in August 1950, milk distribution started in November, and the first serologic tests were performed in the laboratory in December. The paediatrician and the midwife-public health nurse started their work in December 1950. A WHO obstetrician joined the team in August 1951. This pilot project ended in November 1951.

A daily children's outpatient clinic, daily ward rounds in the maternal hospital, thrice weekly outpatient clinics for children and women, thrice weekly examination of kindergarten children, and a child welfare centre operating once a week, kept the WHO paediatrician and nurse busy. The progress of their activities was slow at the beginning owing to language and other difficulties, but to compensate for this, the willingness and co-operation of the Afghan people were gratifying. They found that the mothers were usually young and inexperienced; grandmothers had more influence in the family, being more experienced, and many grandmothers were sympathetic and co-operative. They discovered that abortions and stillbirths (foetal deaths) were common and that many severe cases of osteomalacia came to the maternity hospital. Bowel diseases, venereal diseases, malaria, otitis media, tuberculosis, skin diseases, ascariasis, and food deficiency diseases were prevalent among infants and children in the hospitals, as well as during touring surveys. The Ministry of Public Health was requested to initiate a reorientation course in paediatrics for practitioners in Kabul. The course is run by the WHO paediatrician, in association with Rozantoon Society and the Ministry of Public Health. Training in public health nursing and paediatric nursing, as well as

work on the social aspect of paediatrics, gradually developed.

In 1952, the project continued under the WHO Technical Assistance funds, with equipment and supplies provided by UNICEF, with the following international staff: in Maternal and Child Health, one obstetrician, one paediatrician, one paediatric nurse, one nurse tutor, one midwife tutor, one domiciliary midwife tutor, one public health nurse; in Venereal Diseases, one venereologist, one clinical pathologist, and one venereal diseases nurse. One international fellowship in obstetrics was provided.

Maternal and Child Health. The domiciliary midwife tutor developed a domiciliary midwifery service and intensified the work at the antenatal and postnatal clinics. These facilities are available to the midwifery school for training purposes. One new welfare centre for children was started in the beginning of the year and another established during the course of the year. About a thousand children were registered at the first centre.

For 1953, it was proposed to continue the international staff as in 1952, out of WHO Technical Assistance funds (with equipment and supplies from UNICEF), and to provide for one additional public health nurse for the further expansion of the work.

Provision has been made for four maintenance and travel grants for an MCH refresher course of three months' duration in Kabul. The course is given by the international and national team members and is meant for provincial medical officers as a preparatory step toward the future development of MCH in the country.

By the end of 1953, the work will have been fairly well established and expansion of training and field activities in Kabul initiated. The first group of trainees at the midwifery school will have completed their training.

In 1954, it is proposed to make provision for the continuation of the international personnel as in 1953 for the purpose of sufficiently consolidating the work already carried out.

It is hoped that by the end of 1954:

1. Obstetric and paediatric hospital services will be fairly well-established.
2. Clinics for MCH work will be developed over most of Kabul city.
3. Training of nurses and midwives will be put on a firmer basis.
4. As a result of conducting refresher courses, national personnel will become available to initiate MCH services in some parts of the country outside of Kabul.

Venereal Diseases. A serologic survey was performed in one institution in Kabul, where 2,048 blood samples were examined, with 148 positive seroreactions. In a rural community in Hazarajat, a serologic survey showed eight positive reactions from 93 blood samples. In a survey carried out in Herat, among students from boys' and girls' schools, hospital and clinic patients, and prisoners, in a total of 302 blood samples, 38 positive reactions were discovered. The incidence of VD, as estimated from short surveys, is 10 percent of the population in Kabul; 10 percent in Herat; 4 percent in Hazarajat; and about 2 percent in Pul-i-khumari. Plans for expansion of the activities were made final in 1951. Various types of up-to-date serologic tests were tried out and the serologist found that the VDRL test was the more reliable, simple, and suitable. The Kolmer test was also found practicable and it was thought that this test should also be taught to Afghan technicians.

By the end of 1951, a full scale WHO/UNICEF team was in the field, with a serologic laboratory developed at the central public health laboratory, where diagnostic facilities could be made available to institutions in Kabul and to medical practitioners. The WHO serologist had been replaced by a clinical pathologist. The midwifery school, with an enrollment of 13 students, had started functioning during December. A first class VD service in Kabul, and an arrangement for training and teaching in anti-VD work as well as serology, had been started since the arrival of the WHO venereologist.

In 1952, the laboratory work was expanded and well established, owing to the government having made available the requisite extra space, personnel, and an animal house, in addition to equipment, furniture, and fittings. A training course in laboratory procedures was initiated in January 1952, in which four assistant doctors enrolled for a six months' course together with 10 student technicians for a two year course.

In January 1952, an international venereologist and a public health nurse were added to the team. A new VD clinic, including national staff and with equipment and supplies provided by the government, was opened in March 1952. By the end of 1952, a model clinic and a laboratory were operating where trainees from outside of Kabul receive their training. Provision was made for two international fellowships, each of 12 months' duration; one for laboratory training and the other for training in dermatology and venereology.

For 1953, provision was made for the continuance of the 1952 international personnel, while it is ex-

pected that the government will undertake the expansion of the VD control work to two provincial centres, Kandahar and Herat, with national staff trained at Kabul and equipment and supplies provided. Provision exists for one international fellowship for MPH, majoring in VD.

By the end of 1953 it is expected that:

1. The activities of the clinic and the laboratory will be placed on a firmer footing and further expanded.
2. Teaching activities will be expanded to meet the requirements of the different categories of medical and paramedical personnel.
3. The national pathologist trained abroad will return and serve as understudy to the international pathologist.

For 1954, it is proposed to continue the international staff as in 1953, with supplementary supplies. It is planned to hand over the direction of the project to the national staff by the middle of the year, with the international staff continuing thereafter in an advisory capacity. By this time, active work will have been established in some of the towns outside of Kabul.

It is expected that the government will expand VD control work to another two provincial centres, Mazare - Sheriff and Jalalabad, with nationals trained at Kabul, and equipment and supplies provided under the WHO Technical Assistance budget. It is proposed to provide two regional fellowships; one in pathology and serology, and the other in nursing, each for 12 months' duration.

By the end of 1954 it is anticipated that:

1. The clinic and the laboratory facilities will be well-established.
2. Training programmes will be well-organized.
3. National counterparts will be adequately trained and will take over the responsibilities for the work organized by the international team.
4. An adequate number of nationals will be trained to admit expansion of work outside of Kabul.
5. Four provincial centres will be established.
6. The VD problem in different parts of the country will be defined, a good VD service made available to the people in Kabul, and similar services initiated in other parts of the country.

In respect of this joint MCH/VD programme, the government has provided all personnel, materials, supplies, equipment, and services necessary for the project. It has also provided counterpart personnel and other professional staff, and ancillary and subordinate staff required for the successful execution of the programme. The government has also provided adequate premises, transportation, and lodging, for the international personnel.

Nursing

The number of trained nurses is inadequate to meet even the existing hospital requirements. The majority of nursing personnel are males. Female nurses are few and are to be found only in the hospitals for women at Kabul. The available training facilities are: one school for male nurses, and one school for female nurses which was started only a few years ago. These schools lack trained tutors, teaching equipment, and supplies. Further, the quality and content of the training curriculum need improvement. Until recently there was no organized training of midwives available in the country.

A properly trained nursing staff is necessary to provide adequate medical and public health services to a community. In the circumstances, the development of nursing service was considered appropriate for international aid.

In 1952, under the WHO regular budget, provision was made for two international male nurse educators, with equipment and supplies for the School of Nursing (male) at Kabul. This project is to last two years in the first instance.

The government provided matching personnel, furnished accommodation for the international staff, classrooms, secretarial assistance, office requisites, and transportation. The government undertook to continue the work on the withdrawal of international personnel.

For 1953, provision was made under the regular budget to continue the international staff of two male nursing tutors, with additional supplies. It was proposed to provide for two regional fellowships of 12 months' duration for male nurses.

In addition, provision exists for six selected male nurses to undertake a three months' refresher course in nursing. The international personnel attached to the WHO project, together with the national nurses and medical officers, conduct the course. By the end of 1953, it is anticipated that a fair amount of progress will be made in the development of the nursing education project.

In 1954, it is proposed to continue the international staff of two male nursing tutors with supplies. Further, to assist and strengthen the programme it is proposed to provide (under the regular budget):

1. One international fellowship of 12 months' duration;
2. Maintenance and travel costs for six selected male nurses to undergo a nursing refresher course of three months' duration.

It is expected that by the end of 1954 further progress will be made to place the programme on a firm footing.

In 1952, a nursing training programme at the female School of Nursing at Kabul was initiated under the MCH/VD project, with one sister tutor.

For 1953, provision for one additional sister tutor, together with supplies and equipment, exists under the regular budget.

In 1954, it is proposed to continue the project with the international personnel as in 1953, with supplementary supplies under the regular budget. It is anticipated that by the end of 1954 encouraging progress will be made, both in the organization of the work and by attracting suitable candidates to the nursing field.

Environmental Sanitation

There is no division of sanitation in the Ministry of Health. The government was anxious to institute training and teaching programmes for such personnel as might reasonably be expected to carry the message of healthful living to rural Afghanistan.

In 1952, with an aim to develop these services, the public health engineer was continued under WHO's regular budget. Provision under the regular budget was also made for an international fellowship in public health engineering of 12 months' duration.

The government on its part has offered all necessary co-operation in the work of the public health engineer. It has provided furnished living quarters and met all incidental charges connected with his work. An understudy has been assigned. It is hoped that in subsequent years, when the work develops, it will be integrated into the national health service. Proper water supplies, sanitary disposal of human excreta, adequate housing, and insect control are necessary for the economic development of the country. Lack of these conditions results in a high incidence of disease, puts a strain on the meager resources of the community, and hampers improvement of economic conditions.

In 1953, the services of the public health engineer were continued under the regular budget. He is assisting in developing standard designs of sanitary installations for urban and rural communities. He also assists in the survey, design, and execution of water supplies and sanitary installations for government institutions and other public buildings in Kabul. He participates in the training at the Malaria Institute, Kabul. His services are available to the municipality of Kabul in matters relating to public health and environmental sanitation. It is hoped that the national counterpart will continue as understudy to the international public health engineer after completion of his studies abroad.

In 1954, it is proposed to make provision to retain the public health engineer to consolidate the work initiated by him during the previous years. He will gradually hand over his responsibility to the trained national.

Conclusion

The impact of international assistance in the field of health has definitely aroused a consciousness among the people and the government of Afghanistan. The services rendered by the organization have been appreciated and programmes in the country have a bright future. It is hoped that basic services to the community will be developed. Such programmes are long-term activities which need perseverance, an unlimited fund of patience, and the capacity to understand and appreciate the aspirations and cultural background of the people who are reputed for their honesty, integrity, sincerity, and hospitality. To state that the activities of the organization have placed the United Nations on the map of Afghanistan would be no exaggeration.

The Work of WHO on Virus and Rickettsial Diseases

A. M.-M. Payne, M.D., M.R.C.P.

THE GREATER PART of our knowledge of virus and rickettsial diseases has been gained during the past 30 years. In the last decade in particular, advances have been rapid and, as a result, in many parts of the world the practical application of new knowledge is not keeping pace with its acquisition. A number of countries have no virus laboratories or trained virologists, whereas others have only one or two whose work is chiefly confined to research. In few countries has virology been developed to such an extent that it plays a rôle comparable with that of bacteriology in public health and clinical medicine. Old ideas that viruses are something mystic, somewhat like the "miasmic" causes of communicable disease of the era before Pasteur, persist in some places. Cultivating a virus in the laboratory is still regarded by some investigators as a matter so difficult and highly specialized as to be of no practical value.

A consequence of this is that in some countries there is little appreciation of the importance of many virus diseases. There are, in fact, large areas of the world in which the incidence of various virus diseases is unknown.

Many virus diseases are epidemic diseases and may spread rapidly without regard for man-made boundaries. Indeed many of man's achievements greatly facilitate epidemic spread not only within but between countries. For example, India had apparently remained free from yellow fever virus for centuries, although the vector is widely distributed there, because a journey from endemic areas in Africa formerly took longer than the incubation period of the disease. This is not true now and the most stringent quarantine precautions are needed to prevent its introduction. Many viruses may be transported to other parts of the world. How often this occurs is unknown. However, it is clear that the incidence of virus diseases in a country is potentially a matter of international concern, and that the various problems can only be solved by international co-operation.

It is considerations such as these which lie behind the work WHO is doing on virus and rickettsial diseases. The work may be divided into several broad categories:

1. Assisting countries in the application of well-established control measures in the most efficient manner, such as, smallpox and yellow fever vaccination.
2. Adapting newer control measures to local conditions and helping in their application, such as, vector control in yellow fever and louse-borne typhus.
3. Co-ordinating research on an international scale by bringing research workers in many countries into closer contact and encouraging their participation in world-wide studies, including the provision of standard reagents to ensure comparability of the results, such as, the WHO influenza programme and the biologic standardization of anti-Q fever serum.
4. Bringing together groups of leading authorities on particular diseases from different countries to advise on specific problems and to publish their reports, so as to make freely available the most up-to-date and authoritative opinion as a guide to all national health authorities, such as Expert Committees on Trachoma, Influenza, and Infectious Hepatitis (WHO Techn. Rep. Ser. Nos. 59, 64, and 62 respectively).
5. Arranging for and assisting in the carrying out of specific research on important problems and the practical application of the results, such as, research on dried smallpox vaccines.

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6. Providing experts to undertake surveys of the incidence of certain virus diseases in various countries and of the presence of insect vectors and the delineation of endemic and receptive areas, such as those of yellow fever.
7. Training virologists by providing fellowships and consultants, and by seminars.
8. Providing standard reagents, supplies, and equipment for virus laboratories and other purposes.
9. Collecting and distributing epidemiologic information regarding the occurrence and spread of epidemics and the incidence of various diseases.
10. Undertaking extensive activities in connection with international quarantine.

Some of these activities need not be enlarged on in this report; others will be clarified in the course of the discussion of individual diseases below.

WHO has undertaken work on the following virus and rickettsial diseases: smallpox, yellow fever, trachoma, influenza, infectious hepatitis, poliomyelitis, rabies, arthropod-borne encephalitides, louse-borne typhus, and Q fever. Space does not permit a detailed account of all the work done and therefore only the more important or more interesting aspects will be considered.

Smallpox. Here we find perhaps the most striking example of the practical application of knowledge lagging behind its acquisition. The essential facts necessary for the control of smallpox have been known for more than 100 years and yet in the last 13 years about two and a half million cases with one million deaths were reported. These figures are only a fraction of the actual number, since no information is available from large sections of the world. If we examine the possible reasons for this failure, we are led to suspect that the principal ones are:

1. Inadequate development of health services.
2. Public inertia or even opposition.
3. An incorrect epidemiologic approach leaving endemic areas uncontrolled owing to the lack of knowledge or to difficulties of communication.
4. The use of inactive vaccines, especially in tropical areas where glycerinated lymph deteriorates rapidly.

It is thought that in some areas the use of inactive vaccines is the most important single reason for failure to control smallpox. Difficulties of communications make it almost impossible to bring glycerinated lymph in an active state to outlying areas. It is obvious that an acceptable dried vaccine, with its greatly improved temperature resistance, would go a long way to overcome this problem. Accordingly WHO, through its Regional Office for the Americas, the Pan-American Sanitary Bureau, is undertaking the problem by helping to establish dried vaccine producing plants in the appropriate areas. WHO Headquarters has organized research on the problems of manufacture, temperature resistance, and purity of dried vaccines, both lymph and egg, and will follow up the laboratory results with field trials.

In other parts of the world it seems that lack of knowledge of the incidence of the disease is a principal reason for the failure to control smallpox. WHO is sending epidemiologists to survey this situation and to assist governments in planning mass campaigns to eliminate the endemic areas from which epidemics originate.

However, it needs to be stressed that smallpox can only be effectively controlled by permanent national health services. A mass campaign, unless it is followed by regular revaccination, may be followed, after an interval, by epidemics of smallpox and "epidemics" of vaccination, a situation which is wasteful both in human life and in money. Therefore, the efforts of WHO to assist in the development of national health services and in health education of the public are essential to the permanent control of smallpox.

Yellow Fever. The history of yellow fever is so bound up with that of the American continent that it needs no repetition here. WHO, through its Regional Office for the Americas, has continued control measures begun long before WHO came into existence. New methods of vector control based on modern insecticides have greatly increased the effectiveness of the programme; large areas in which the disease was formerly endemic are free. On the African continent, WHO has undertaken large-scale serologic surveys in order to delineate endemic areas, and vector control has been undertaken with success in a number of places. In addition to these activities WHO, through its Yellow Fever Panel of experts, keeps a close watch on the quality of yellow fever vaccines.

Trachoma. Visitors to North Africa are familiar with the sight of crowds of children staring at them with inflamed eyes ringed by a black circle of flies. They see too the hundreds of blind adults, reduced to beggary, with their scarred and distorted eyelids. That is what trachoma does; children are infected early in life and many become blind and poverty stricken. There are millions of sufferers in Africa, the Eastern Mediterranean region, Southeast Asia, and elsewhere. Until recently there has been no cure,

but with the advent of sulfonamides the outlook changed, and it has improved still further as a result of the use of antibiotics. The disease, especially in its early stages, can now, in the majority of cases, be readily cured. However, problems remain since the treatment is not readily adaptable to mass campaigns which are necessary to eradicate the disease from an area, and the drugs are costly; too costly, because trachoma is essentially a disease of poverty and poor hygiene, although if the money can be found, it is rapidly more than compensated for by the considerable economic value of the restoration to health of the workers. In Tunisia, for example, a country of 3,500,00 inhabitants, about 25 million working days are lost each year through trachoma and other eye diseases.

In 1948, a joint Office International d'Hygiene Publique/WHO study group on trachoma was set up to review the existing knowledge of the disease. As a result of its recommendations, investigations were carried out at a number of institutes under the aegis of WHO, and in 1952, an Expert Committee was convened to consider the results. The Committee was able to make precise recommendations as to how mass campaigns could be carried out (WHO Techn. Rep. Ser. No. 59), and pilot projects based on these recommendations have already commenced. If these are successful, as there is every reason to hope, the large-scale control of trachoma might be undertaken and its achievement will be only a matter of time.

Influenza. Even in its present relatively mild form, influenza may cause many deaths and be responsible for considerable economic loss. This alone would make it important to learn how to control the disease, but it is even more vital to discover how to repel the attack of a lethal influenza pandemic, such as that of 1918 and 1919, in which it is believed at least 15 million people died throughout the world. No one knows the combination of circumstances which brought the disaster about. However, assuming that it was caused by a variant of the influenza virus, there is a real basis for anxiety, because the influenza virus within certain limits shows no stability in nature, and a variation which has occurred once may occur again.

The instability of the virus is important for another reason. Virus A vaccines must be made from strains closely related to the epidemic strain if they are to be effective. This necessitates a constant study of the antigenic pattern of new strains as they arise, which must be carried out with all speed so as to allow time for their incorporation in vaccines if they are found to differ significantly from earlier strains. Influenza spreads so rapidly that the results of such studies come too late to be of use to the country originally affected, but they may prove of the greatest value to countries and continents not yet involved, thus illustrating the need for an international approach to the control of this disease.

The importance of some of these considerations was appreciated as long ago as 12 years when the United States Armed Forces Commission on Influenza set up a network of laboratories with a central reference laboratory for the study of the influenza virus and its epidemiology. When WHO was being formed in 1947 it was natural that a similar plan should be adopted and extended, until now there is a network of 54 laboratories for the study of influenza in 43 countries throughout the major part of the world, with two central reference laboratories in London and New York. The functions of these laboratories are: to provide early information regarding the occurrence of epidemic influenza in a country; to identify the type of influenza, preferably by virus isolation or by serologic tests; to dispatch as quickly as possible any virus isolated, particularly those showing any unusual clinical, epidemiologic, or virologic features, to the appropriate reference laboratory where further studies are carried out. Strains of virus showing unusual features are made available as soon as possible, so that if necessary they can be used for vaccine production. Reports on the incidence of influenza are transmitted, by cable if necessary, to the reference laboratories and to the epidemiologic services of WHO, which in turn distributes them to all health authorities in the various weekly publications distributed from Geneva, Washington, Alexandria, and Singapore. In time of epidemics, reports are transmitted from WHO by cable or in the daily radio bulletins, which reach all parts of the world. The results of laboratory investigations are distributed in the same way as soon as possible.

A major purpose of WHO's influenza programme, and in particular of the two reference laboratories, is the study of the epidemiology of influenza, in the hope that eventually it may become possible to forecast epidemics with reasonable accuracy, including the type of virus expected to be responsible. There is much to be learned before this can be done. However, never before has it been possible to collect and to compare strains of virus isolated throughout the year in most parts of the world, and much valuable information has already been gained.

In co-ordinating the work of laboratories in different parts of the world, one problem is to ensure that the results obtained in different laboratories are comparable. In the report of the Expert Committee on Influenza (WHO Techn. Rep. Ser. No. 64),

standard diagnostic techniques are described in detail, and as a result of recommendations by the Committee, WHO is supplying standard reagents to laboratories in the WHO Influenza network.

Louse-borne Typhus. There are still a number of problems in the control of louse-borne typhus. However, the use of modern insecticides in powder form to reduce or eradicate the louse population during epidemics has proved a great advance. WHO is adapting this method to the routine control of typhus. In some countries, typhus epidemics begin with great regularity about a certain date. If, therefore, extensive dusting operations are carried out just before this date the epidemic should theoretically be aborted. The first large-scale trials of this technique in Afghanistan have apparently been highly successful, although further trials must be undertaken before conclusions can be drawn owing to the occurrence of unpredictable variations in the incidence of the disease. For the most part DDT powder has been used in these trials. Unfortunately, recent experience in Korea has shown that lice totally resistant to DDT may emerge and when this happens, recourse must be made to other insecticides.

Rabies. Recent advances in rabies control have been the result of the work of a handful of specialists scattered throughout the world. WHO has brought this work to the attention of many countries in the Eastern Mediterranean and Asian regions by holding an important conference at Coonoor, India, which included lectures, discussions, demonstrations, and laboratory training conducted personally by several of these specialists.

For two and a half years WHO has sponsored a field trial in Israel to demonstrate control of rabies by mass vaccination of dogs with egg-adapted virus vaccine. The results have been highly encouraging; no vaccinated dog contracted rabies following the interval necessary for the vaccination to confer immunity, and no human case was reported during this period, whereas 16 human deaths had occurred during the previous two years.

Trials of the therapeutic value of hyperimmune serum are in progress and preliminary results are encouraging, though as yet insufficient for statistical analysis.

The work of WHO on these and other virus diseases is continually being developed and extended to take into account new needs as they arise. The ultimate objective is that virology should take its rightful place beside bacteriology in public health and clinical medicine by the practical application of existing knowledge and future discoveries in the control of virus diseases in all parts of the world.

Environment and Health

R. N. Clark

IN THE WORLD TODAY, one of the appalling facts is the high percentage of illness and death which results from faulty environment. Figures are cold, they do not express the suffering, the weakness, the despair, the grief, to say nothing of the loss in productive and vital capacity which lie behind each digit, but one stark figure may give an insight into the picture: One fifth of all cases of illness in the world today are diseases transmissible through the environment.

Disease and death strike at every age, but the effect of bad environment is felt most strongly on infants. It is difficult to obtain accurate and reliable figures from regions where health services are undeveloped. Those figures which are available, however, indicate quite clearly that in undeveloped regions, infant mortality ranges from one fourth to one third of all live births. Sanitation bears a direct relationship to infant and child health and survival. Enteric infections lay a heavy hand on infants, whose immunity is low, and whose vigour is often not sufficient to cope with an infection after it becomes established. Deaths from diarrhea and enteritis constitute a substantial proportion of all infant deaths.

A survey of conditions in 22 selected countries where figures are available[1] has shown that the range is from a maximum of 175 infant deaths per thousand live births, of which 54 percent were caused by diarrhea and enteritis, to a minimum of 22 infant deaths per thousand live births, of which 2.3 percent were caused by diarrhea and enteritis. The decrease in the percentage of deaths caused by enteric disorders illustrates perfectly the relationship between sanitation and good infant health.

Another problem of infant and child health is parasitic infestations. Field investigations of intestinal parasitism have shown high infestation rates of children in areas in different parts of the world. Hookworm frequently infects an important percentage of the population, 50 to 80 percent and above. Ascaris probably is the most prevalent and widespread of all human parasites. It is more prevalent in young children, in whom, despite constant loss of worms, high levels of infection are maintained by continuous reinfection from the polluted soil close to the houses in which they live. One medical observer[2] has stated that the worms infesting the people of a certain semitropical country metabolize more of its produce than do the inhabitants.

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Looking in another direction, and considering the matter of drinking water supplies, it is apparent that the water-borne diseases affect not only the children but whole populations. In the more highly developed countries, the purification of water supplies has played a substantial part in the reduction of mortality rates. In such areas, not only cholera and typhoid fever, but also the various forms of dysentery, have almost disappeared. Several years ago, prior to the establishment of a co-operative bilateral programme in the Amazon Valley, Brazil, there was an area two-thirds the size of the United States in which only two cities had adequate and safe water supplies. The report on this project stated, "The incidence of typhoid fever and other water-borne diseases was extremely high, as was the infant mortality rate and intestinal parasite infection rate. One of the most important parts of the engineering and sanitation phase of the work has been the construction of safe public water supplies in the smaller communities, ranging in size from 500 to 10,000 inhabitants." In one of these towns, where there had been 20 to 30 cases of typhoid fever each year, not a single case occurred after a small, economical, and safe water supply system had been provided.

In a large part of the world, water-borne diseases are still a serious drain on health. In Mexico, at a ceremony inaugurating the installation of nine new water supply systems in 1948, a Cabinet Minister said: "Water supplies and storage services in our cities are very important when we consider that 22 percent of the general mortality rate is caused by water-borne disease."

Another major sanitary problem is housing. In this field there is a double aspect, the disease potential arising from insanitary conditions on the one

hand, and the effect of bad housing on physiologic and psychologic health on the other. The problems fall into distinctive groups, including the environment of the home, such as, sanitary facilities and town planning; home occupancy, such as, basic relations of space and planning to housekeeping activities and mental hygiene; and the construction and equipment of the home with regard to heating, lighting, sound control, and freedom from accident hazards. The destruction of war, the diversion or absence of building materials, the increase of urbanization, and the progressive deterioration of buildings have all had a part to play in a housing problem of world-wide extent. As one example, in the United Nations Bulletin "Housing in the Tropics," it is stated: "In the Caribbean area, housing is one of the most pressing problems from the point of view of public health, as well as in economic and social terms. The lack of space in rural dwellings, combined with poor building materials and inadequate ventilation, are contributing factors in respiratory infections, while intestinal diseases can be traced in part to improper disposal of excreta and refuse, and impure water supply." The report goes on to show the relation of housing to tuberculosis, pneumonia, and intestinal diseases, all of which have a serious impact on the people of this area.

Cleanliness of food is another basic world-wide problem. Excluding the nutritional aspects, the amount of illness arising from food-borne infections is incalculable. The filth diseases, such as typhoid and dysentery, are reported, to some extent; infant diarrhea has already been mentioned, and its incidence has been estimated; but most of the cases of gastroenteritis and similar episodes are unreported and unnoticed by health agencies, which make their estimation virtually impossible. The safety of meat supplies, of milk and milk products, the standards of food handling, preparation and service in restaurants and other public eating places, all these and others are sanitary problems of great magnitude, which are not unnoticed by the affected persons, and which reduce production and the general level of health to a significant degree.

The subject of food introduces the question of household and personal cleanliness in relation to disease. Pure water and safe food are meaningless if carelessness in the home results in infection at the point of use. In situations and cultures where homes and furnishings may be primitive, where dirt is the rule, where lack of knowledge and indifference are virtually universal, the transmission of disease in the home is extremely serious. Scott, in his book "Health and Agriculture in China," reports on surveys of farm homes in Northeast China. Samples of earth were collected from the living room floors and examined for the eggs of *Ascaris lumbricoides*. He found where families were heavily infested, 46.8 percent of such samples were positive. Where the family infestation was classified as light, the rate was 34.2 percent positive.

Household and personal cleanliness is related not only to intestinal infections, but to a great many other disease conditions as well. The spread of trachoma has been observed to follow the degree of cleanliness of a household. The interesting observation was made by a WHO trachoma expert who found that on an island in the Mediterranean, two communities, similar in size, location, fly density, and other considerations, had widely different trachoma rates, one community being heavily burdened with trachoma, the other having practically none. The most obvious difference in the communities was in household and personal cleanliness, the trachoma-free community being much cleaner in these respects than the other. The WHO Expert Committee on Trachoma said:

> "Any programme for trachoma control must be directed not only against the disease itself but also against related and associated conditions and against epidemic conjunctivitis . . . The basic principles of trachoma control include . . . destruction of possible vector agents, and other environmental sanitation measures." (WHO Techn. Rep. Ser. No. 59.)

Another example is taken from Dr. E. I. Grin's report "Epidemiology and Control of Endemic Syphilis," in which he states:

> "The mode of transmission of endemic syphilis in Bosnia is mostly nonvenereal in character. The rural population does not generally associate the disease with sexual contact, and endemic syphilis does not exhibit the epidemiological and other characteristics of a venereally acquired disease. The use of common utensils, and particularly of drinking vessels passed from mouth to mouth offers opportunities for indirect transmission of the infectious agent. Added to this are other unsatisfactory conditions of sanitation found in infected villages, which explain the fairly even distribution of endemic syphilis between the two sexes."

Household cleanliness relates also to the control of bedbugs, flies, fleas, and other vectors of disease, as well as to insect pests, but the question of vector control goes far beyond good housekeeping. The scourges of malaria, yellow fever, typhus, filariasis, bilharziasis, trypanosomiasis, plague, relapsing

fever, and many others are almost unbelievably severe. In Burma, over 600,000 cases of malaria have been hospitalized in a year, with a death rate of 214 per 100,000. In India, with over 1,000,000 deaths from malaria each year, 60 percent of the population of Bengal has malaria each year.[2] In many countries in which bilharziasis is endemic, evidence already available indicates that it is a public health problem second only to malaria. The debilitating nature of the disease is a markedly deterrent factor in food production. Mention cannot be made of the others, but where these vector-borne diseases occur, they are exceedingly serious problems.

So far, emphasis has been put on those diseases which strike principally at underdeveloped areas. This does not mean that highly developed and highly industrialized regions are without sanitary hazards. Industry brings with it the problems of occupational health and the effects of chemical, physical, mechanical, or biologic agents found in industry. It also brings with it an impact on the public health, in terms of atmospheric pollution, stream pollution, community and housing congestion, migration of large groups of workers and their families, and many others. The complexity of sanitation problems in a country with highly developed economic and industrial resources far exceeds that met with in more primitive cultures.

This, then, defines environmental sanitation. The term as used by WHO refers to the control of:

1. Methods for the disposal of excreta, sewage, and community wastes to ensure they are adequate and safe.
2. Water supplies, to ensure that they are pure and wholesome.
3. Housing, to ensure that it is of a character likely to,
   a. provide as few opportunities as possible for the direct transmission of disease, especially respiratory infections,
   b. encourage healthful habits in the occupants.
4. Milk and other food supplies, to ensure that they are safe (the question of their nutritive quality being excluded from consideration).
5. Personal and public habits of cleanliness, especially in relation to disease.
6. Arthropod, rodent, mollusc, or other alternative hosts associated with human disease.
7. Atmospheric conditions, to ensure that the external atmosphere is free from deleterious elements and that the internal conditions of workshops, houses, and so forth, are suitable for the occupations undertaken in them.
8. Factories, workshops, dwellings, streets, and the general environment, to ensure freedom from risk to health whether mechanical, chemical, or biologic, and to provide the best working and living conditions.

To meet these problems, WHO believes that everything possible should be done to strengthen the sanitation services of national health agencies. The WHO Expert Committee on Environmental Sanitation says: "The highest priority should be accorded to the strengthening of governmental agencies specifically charged with the responsibility for initiating, promoting, and persisting in environmental sanitation by direct and indirect participation and influence."

This is done by assisting with the training of professional personnel, by proposing international standards in environmental sanitation, by loaning international experts to governments, by carrying out local demonstrations, and by every other possible means of stimulation. It is clear that more people are willing to give lip service than to work, and one of the greatest tasks today is that of education; to convince and move to action by facts and persuasion, all responsible persons who can make a programme possible, and above all, people who, through lack of knowledge, carelessness, laziness, or indifference, are failing to protect their own or others' health. The main attack must always be education and persuasion, a programme armed with facts, with specific aims in view, and unshakeable in its integrity. It is a great challenge, but great rewards can come with success.

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World Health Organization Activities of 1952

SUMMARY FROM ANNUAL REPORT OF THE DIRECTOR-GENERAL, DR. BROCK CHISHOLM

THE ORGANIZATION has now passed through its formative period. Its general policies and procedures and its relationships, both internal and external, have been established. A high standard of responsibility on a world level has been set by the World Health Assembly, with relatively few intrusions by concern for national or group interest or prestige. The maintenance of this standard is an essential factor in enabling the Organization to function as a whole.

The Executive Board, to be able to fulfill its highly important role as technical adviser to, and executive organ of, the Assembly, is composed of members responsible to the Assembly alone, not to governments or any other bodies. For the most part the Board has lived up to this responsibility. It is absolutely essential that the Assembly should be able to feel complete confidence that the advice it receives from the Executive Board is based on technical considerations, and is entirely free from national or group interest of any kind or degree. Nothing short of complete world-mindedness is acceptable in any member of the Executive Board.

Perhaps the most serious demand that WHO makes on its member governments is that they should ensure these personal qualifications in the members whom they designate to the Executive Board, and then should respect the absolute independence of those designated. These same requirements apply equally to any alternates or advisers who may accompany members at meetings. Only governments can so protect members of the Executive Board and enable them to carry out their proper functions; nothing less can meet the needs of the Assembly for unprejudiced technical advice.

After six and a half years of development, the Secretariat may now be said to have welded itself into an integrated and balanced instrument for carrying out the intentions of the Assembly and the Board. The early stresses engendered by the absorption of previous agencies and of individuals from many cultures have been almost entirely resolved. All administration has been undertaken on the principle of mutual consultation on the widest possible basis before decision. Further, all administrative decisions have been provisional to the greatest degree consistent with reasonable stability. On the whole the Secretariat is competent, devoted to the ideals and the methods of work of the Organization, and ready, within the limits of human capacity only, to assume whatever responsibilities may be laid on it by the Assembly or the Board. Essential elements in the maintenance of the reliability and efficiency of the Secretariat are world-mindedness of delegates to the Assembly, even greater world-mindedness and absolute independence of judgment of members of the Board, and the complete freedom of the Secretariat from pressure or even suggestion from representatives of governments.

REPORT OF WORK IN THE REGIONS

AFRICAN REGION

One of the first tasks in setting up the Regional Organization for Africa was to make contact with government authorities in many territories in order to understand their wishes and needs. For this purpose, following his visits to other parts of the Region in 1951, the Regional Director, in January 1952, visited Pretoria, Union of South Africa, where he had discussions with the chief medical officers of the Union. The next step was to survey various territories in Africa in cooperation with the heads of the local medical departments. In April of 1952 discussions were held in London with the Secretary-General of CCTA, who attended the Fifth World Health Assembly and the second session of the Regional Committee for Africa. This last was held in Monrovia, Liberia, from July 31 to August 7, and all members of the Regional Committee were represented: Belgium, France, Liberia, Portugal, Spain, the Union of South Africa, and the United Kingdom; the representative of the associate member, Southern Rhodesia, was unable to be present. There were also representatives or observers from the United Nations, the European, African, and Eastern Mediterranean offices of UNICEF, ILO, CCTA, the American College of Chest Physicians, and the League of Red Cross Societies. The Director-General of WHO attended this session and also paid visits to areas in Northern Liberia and to Nigeria, French Equatorial Africa, and the Belgian Congo. The Government of Liberia co-operated fully in providing all facilities for a successful meeting and the session was opened by the President of the Liberian Republic. A programme of some 60 projects was proposed for 1954, and the recommendations made included an early review by the Director-General of the difficulties in recruiting staff for the Regional Office for Africa. In spite of exceptional recruiting difficulties, the essential staff for the Regional Office was recruited by the end of September, and moved to Brazzaville in October.

Several surveys were undertaken or continued. The survey on bilharziasis carried out by three experts on behalf of WHO was continued during the year. In addition a nurse with long experience in Africa started work on a survey in preparation for a nursing conference in 1953. A consultant studied malaria in some of the West African territories with a view to antimalaria campaigns, and a psychiatrist made a survey of African psychiatric and psychologic problems to prepare for the conference on problems of childhood in tropical countries of Africa which was arranged by the International Children's Centre and held at Brazzaville in December. The agenda for this conference included an item on African child psychology.

A meeting of the Expert Committee on Yellow Fever was planned for 1953 to consider the delineation of the

southern limit of the yellow fever endemic zone in Africa, which was studied by the governments of the territories concerned, with the co-operation of laboratories of the Yellow Fever Research Institutes in Johannesburg and Entebbe.

The Regional Office tries to establish close contact with the many specialists with wide experience who are being sent out to non-self-governing territories by the metropolitan authorities or institutions, and, with the consent of the authorities concerned, arranges conferences between such specialists and its own personnel working on the same subjects. An example was a conference arranged with a tuberculosis specialist sent out to West Africa by the Colonial Office of the United Kingdom.

The training of African doctors and auxiliary personnel needs to be encouraged and intensified. Fellowships were accordingly granted, partly out of Technical Assistance funds whenever suitable candidates were brought forward by governments. Funds are still available, but in some cases difficulty has been experienced in finding suitable institutions prepared to accept candidates, especially undergraduates. Two important courses were organized during the year. One was a comprehensive nutrition course for medical officers working in Africa, held in Marseilles from April to July, under the joint auspices of FAO and WHO, and financed from Technical Assistance funds. Some 40 doctors and nutritionists attended this course, which ended with a meeting presided over by the French Secretary of State for Overseas Territories. The other was a training course on malaria held during June and July in Lagos, Nigeria. It was organized by WHO, which provided several lecturers. A number of English-speaking doctors working in Africa attended. Plans were made for another such course, for French-speaking doctors, to be given in 1953, perhaps in the French Cameroons, where the WHO-assisted malaria control project is to start operation. In addition, fellowships were awarded to three candidates in the Region for participation in the symposium on yaws held in Bangkok. At the invitation of CCTA, WHO was represented at a nutrition conference in Fajara, near Bathurst, Gambia. This conference, which took place in November, was immediately followed by a session of the Joint FAO/WHO Expert Committee on Nutrition, held in the same place.

Meetings in which the Organization participated included the one mentioned on problems of childhood in tropical countries of Africa; a meeting of the International Scientific Committee for Trypanosomiasis Research in Lourenço Marques, Mozambique; and a conference on housing in Africa organized by CCTA in Pretoria.

REGION OF THE AMERICAS

For several years the workshop has been found an effective means of teaching. The Pan American Sanitary Bureau sponsored the first nursing workshop in Latin America in Chile in 1950. A second nursing workshop (Guatemala 1951), financed from technical assistance funds provided by the Organization of American States, provided a further opportunity for valuable discussions of problems among nurses from many countries. The third workshop (Lima, Peru, June 30 to August 8, 1952) dealt with the teaching of communicable disease nursing and was sponsored jointly by the Peruvian Government, the Pan American Sanitary Bureau, and WHO. The control of communicable diseases remains a problem in all Latin American countries, which lack qualified nursing personnel to deal with these diseases and to teach prevention and nursing care. This workshop contributed to the preparation of nurses for such work. Twenty-three nurses from Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela took part. Themselves directors and instructors in schools of nursing and supervisors of public health services, they were able to bring up problems encountered in their daily routine, and to seek solutions through the interchange of ideas and experience. The discussions, held daily in general sessions, were supplemented by smaller group meetings for the study of common problems. Individual consultation on special problems was also available. Information showed that out of 52 South American schools of nursing only 17 provided courses on communicable diseases, and one of the purposes of the workshop was to stimulate interest in adding this course to the curriculum. A nurse-educator on the staff of the PASB supervised the workshop and was assisted by consultants from Brazil, Chile, Panama, Puerto Rico, and the United States of America, three of whom had acquired valuable experience during the workshops in previous years.

A WHO consultant on meat hygiene completed a survey in the Americas, visiting Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, Panama, Peru, Surinam, Trinidad, Venezuela, and packing plants in the United States (Buffalo and Chicago) and Canada.

As a result of decisions made in October 1951 by the ad hoc technical working party on the rehabilitation of the physically handicapped appointed by the Administrative Committee on Coordination (ACC), a special team, consisting of a leader provided by the Technical Assistance Administration and members from ILO and WHO, went to Latin America to conduct a joint survey of conditions. WHO provided a short-term consultant to ensure that any proposals for rehabilitation programmes were properly related to the general public health and medical care programmes of Latin American countries.

In the summer of 1951 there was a meeting of ILO experts at La Paz, Bolivia, to consider what could be done to assist the indigenous population of the Andean highlands of Bolivia, Ecuador, and Peru, about 10 million people, who, it is believed, could play a much more significant part in the economic life of their countries. The United Nations, ILO, FAO, UNESCO, and WHO are co-operating in a survey as a preliminary to recommending how this may be done. A joint field team consisting of a small group of experts has been appointed. The WHO expert in public health will assist in deciding the areas and groups of population to be included; collate the studies already made on the health problems of these areas; and prepare, in consultation with the health authorities of the countries concerned, plans of operation for suitable pilot health projects, to be organized under the Technical Assistance programme.

In connection with the venereal disease laboratory and training programme in Guatemala City, advisory services were given and courses in venereology and serology conducted for students from Central American countries, Panama, and Haiti, under Technical Assistance. WHO provided a consultant serologist, who arrived in Guatemala on March 12 and gave technical advice on the programme of the laboratory. He made field trips to laboratories and directed a serology survey in Central America and Panama. Assistance was also given through a seminar for team leaders working on venereal diseases, held in San José, Costa Rica, in June, at the same time as the Fourth Central American Congress on Venereology.

The Regional Office for Europe invited the Region of the Americas to participate in the international seminar on mental health and infant development which was held in Chichester, England, from July 19 to August 10. Six fellowships from the Americas were

awarded by the Washington Office for participants from Canada, Mexico, Peru, Puerto Rico, Uruguay, and Venezuela. These participants were also given a stipend to cover an additional four weeks of field observation in Europe.

Arrangements progressed for a South American seminar on alcoholism, to be organized by WHO in co-operation with the Argentine government in Buenos Aires in May 1953. Argentina, Brazil, Chile, Paraguay, and Uruguay will probably participate. Five fellowships for the Yale Center of Alcohol Studies were given to candidates from those countries to assist them to prepare for the seminar.

A programme of insect and yellow fever control in Central America was started with the help of WHO and UNICEF under the Technical Assistance programme. Three WHO staff members were appointed and stationed in Guatemala. For a similar project started in the Caribbean area, also under the Technical Assistance programme, a WHO inspector arrived in Grenada in October and began training field personnel in Aëdes aegypti extermination and DDT residual spraying of houses. Four local trainees completed a course in Puerto Rico and returned to Grenada late in October. Supplies of DDT from UNICEF have begun to arrive. One staff member of WHO was appointed to the Inter-American Center of Biostatistics at Santiago, Chile.

Regional programmes being planned include: the training of environmental sanitation personnel in Brazil, Chile, and Mexico; a training course in insect control in Brazil; postgraduate training in tuberculosis in Guatemala; seminars on brucellosis, health education, and phthisiology in South America; a training course for waterworks operators in Central America; a workshop on the nursing curriculum; and assistance to schools of public health and medicine. At the end of the year, 48 agreements with governments had been signed, for assistance either under the regular budget or from Technical Assistance funds. A seminar on sanitary engineering in Central America was held in Nicaragua in November.

SOUTHEAST ASIA REGION

Programmes in maternal and child health were in operation, with the assistance of WHO and UNICEF, in all six countries of the Region. The maternal and child health programme in Afghanistan went well and had excellent co-operation from the government; training for midwives started for the first time in that country. In the Burma programmes, national trainees took an active part in the work, which emphasized public health aspects. In Ceylon improving the quality of training was stressed. In India, the work at Delhi underwent many vicissitudes, and the whole programme is at present under review; paediatric nurses are not given special training in India at present, but, with the help of a qualified instructor, the subject was included in the basic training of nurses at the Irwin Hospital. In Indonesia, the programme was still in its early phases. In Thailand, the work in Bangkok developed very well, while progress in Chiengmai was slower. The need for including both the preventive and curative aspects in such programmes was recognized, and this in itself is a gratifying result.

Two vital needs in environmental sanitation are protected water supplies and sanitary disposal of human excreta; improvement in these conditions would produce a dramatic advance in health. Because of lack of funds, water supplies in many cities are inadequate, and in rural areas they are commonly polluted. There is no possibility of installing piped water supplies in all rural areas, even in the remote future, but such areas could have protected wells. To provide such wells to over a million villages in Southeast Asia would require heavy initial expenditure, of course, but there are numerous bilateral and international agencies which might finance such projects. Unless better housing and health services invariably accompany industrialization the European experience of slum areas is likely to be repeated. In Afghanistan a WHO sanitary engineer made surveys in Kabul, assisted in plans for sanitary facilities, and also participated in the antityphus campaign.

Calcutta Plague Control Team with woman doctor interviewing Chawl people and injecting antiplague vaccine.

The importance of mental health is beginning to be appreciated. Thailand had the services of a consultant for three months in 1951 and, as a result of his report, the government asked WHO to provide a psychiatrist in 1953, to establish a mental hygiene clinic. In India, a WHO consultant assisted in plans for upgrading the Bangalore Mental Hospital into an All-India Institute of Mental Health, and, on his recommendations, provision was made for further international assistance in 1953 and 1954. Another consultant was made available to Goa (Portuguese India) for one month, and his report is being studied. WHO policy was to create a nucleus in each country around which it will be possible to build future services.

Nutrition is one of the most urgent public health problems in the Region. Malnutrition is due largely to poverty, but partly also to lack of knowledge of what constitutes a well-balanced diet. WHO's assistance in this field has been concentrated on training. A WHO consultant made a rapid survey of nutrition in Burma and suggested a programme, for which a fellowship has been provided; a dietitian was sent to Ceylon to assist in improving and organizing hospital diets; and in Indonesia the Nutrition Institute at Jakarta has been strengthened by a medical nutritionist and a biochemist technician.

To be effective, health education should be at the village level. WHO has included health education in some of the field projects as an experiment. A health educator was assigned to the UNESCO fundamental education project in Ceylon, where the establishment of a health education institute is planned. WHO co-operated with UNESCO in preparing a book on health education suited to conditions in the Region.

A WHO consultant visited India at the end of 1951 and submitted a report on population studies, which was approved in principle by the government. In accordance with his recommendations, two WHO workers arrived in India, and at the end of the year were helping to start pilot studies.

Assistance in nursing instruction was given in all the six countries of the Region. Eight nursing projects have been planned, of which three have already begun. At the end of the year, 46 international nurses were working in the field, and another 22 were due to start work shortly after. Many of them were attached to health projects of which nursing is a subsidiary but essential part. In the nursing programme stress is being laid on the inclusion of public health nursing in the basic curricula of nurses and midwives, and WHO is also assisting numerous schools of nursing.

Refresher courses were arranged for graduate nurses who had been assigned to specialized work for which they had little specific training. During 1952 five such courses, attended by 62 nurses, were developed as separate training projects, four for a period of three months and one for one month.

For the first time, post-certificate training courses in public health nursing were developed in Burma and India. Other organized teaching courses such as refresher courses for midwives and in-service training of midwives and other health workers, as well as the preparation of teaching material, such as procedure manuals, were also undertaken in conjunction with actual projects, and health education programmes were developed and accepted as an important part of all nursing and health services.

Because of the urgent need for properly trained nurses, special attention has been given to strengthening nursing schools and to providing training in nursing as part of field projects. Forty-six fellowships were awarded under the regular budget in 1952, and 42 under Technical Assistance; 18 more were administered on behalf of UNICEF.

The following specialists have been made available to teaching institutions: a professor of epidemiology and social medicine to Afghanistan; a professor of physiologic and industrial hygiene to the All-India Institute of Hygiene and Public Health, Calcutta; a principal for the Medical College at Trivandrum; and a professor of pharmacology for the School of Tropical Medicine, Calcutta. A professor of pharmacology for the Seth G. S. Medical College, Bombay, and a lecturer in tuberculosis for the Rangoon Medical College are under recruitment. Many more requests for professional staff were received. This way of strengthening national institutions reduces the need for fellowships except for junior workers.

Training activities were also important features of the programme for maternal and child health and for the control of tuberculosis, venereal diseases, and yaws.

Malaria continues to be the foremost communicable disease problem in Southeast Asia, but the strength of the national organizations for its control is growing steadily. That the vector species is vulnerable to insecticides has been demonstrated by the work of numerous teams, and large-scale programmes are now on the way in individual countries. In Afghanistan, after the initial success of the WHO team, malaria control was extended to 700,000 people. In Burma, with the collaboration of the WHO team, a five year plan was drawn up. The excellent antimalaria campaign which has been conducted by the Government of Ceylon in the past few years continued. In Indonesia, in spite of the lack of medical personnel, the programme is to be expanded to cover a million and a quarter people. In Thailand, the first phase of a five year plan (started with help from WHO and expanded under United States bilateral technical assistance) is in operation, and covers one and a quarter million people; by 1956 the government proposes to protect 5 million people. The Planning Commission of the Government of India has accorded a high priority to malaria control, and a country-wide campaign is planned, with the assistance of the Technical Co-operation Administration, to protect 200 million people in five years with 200 field units. This will be the largest single endeavour in the history of malaria control in any country.

The DDT plants being established in India and Ceylon with the help of UNICEF and WHO will, within two years, contribute largely towards meeting requirements in those countries. In the meantime the assistance of UNICEF in donating DDT to India, Ceylon, and Afghanistan, with technical advice from WHO, has been most valuable.

Tuberculosis is another pressing problem. During the year six WHO-assisted demonstration and training projects were in operation at centres in Delhi, Trivandrum, Rangoon, Bangkok, Patna, and Bandoeng, with objectives based on the recommendations of the Expert Committee on Tuberculosis. Surveys of different age groups and occupational categories were carried out at Delhi, Trivandrum, Rangoon, and Bangkok, and similar surveys are planned at the other two centres. In the areas surveyed extremely high rates of morbidity, long suspected, were confirmed. At these four centres a sufficient number of doctors, nurses, and technicians were trained to carry on the work after the withdrawal of the international personnel.

At Delhi and Bangkok the existing tuberculosis services have been greatly improved, and the attendance of patients has increased. At Trivandrum and Rangoon new clinical services have been established and are dealing with large numbers of patients; such services are also being set up in Patna and Bandoeng. In most of these centres first class laboratory diagnostic services have been established. The project in Ceylon was limited to work in mass radiography, tuberculin surveys, and the training of radiographers; a tuberculosis laboratory has not yet been developed. The main obstacle to the success of these projects has been the delay by governments in providing matching personnel and facilities such as buildings and fittings.

From July 1951, WHO assumed the technical responsibility for the campaign for BCG vaccination, which had formerly been exercised by the International Tuberculosis Campaign. BCG vaccination will in the future be more closely linked with general projects for tuberculosis control, such as the demonstration and training centres. Mass campaigns for vaccination are in progress in India and Burma, and projects were started in the last quarter of the year in Indonesia and Thailand.

The main objectives in campaigns against the treponematoses, including venereal diseases, have been the development of permanent teaching centres in each country to train staff in modern methods of control, including clinical, laboratory, and social aspects; and assistance to governments in expanding their control work to cover the whole country after suitable personnel have been trained.

In India, following the work of a WHO demonstration and training centre started at Simla in 1949, a permanent training centre more adequately equipped

for the purpose was set up at Madras with WHO and national staff. In addition, UNICEF provided equipment and supplies to 16 states to encourage them to start modern programmes for venereal disease control. Similar facilities, mainly in association with teaching hospitals, were established in Afghanistan, Burma, and Ceylon. In Indonesia, the government is sponsoring a new institute for teaching and research in the venereal and related diseases, for which WHO provided fellowships and some equipment.

In work against the nonvenereal treponematoses, the programmes were directed towards the control of yaws. Projects being carried out in Indonesia and Thailand with the assistance of WHO and UNICEF are now on a scale seldom previously attained in medical history. They have been conducted as mass campaigns in rural areas with field teams under the guidance and supervision of medical officers, and with the active cooperation of the civil administrations. The programmes have been directed by national staff assisted by international personnel. Because of the acute shortage of auxiliary staff, governments are now employing partially trained assistants, who have so far proved keen and reliable. A pilot project with UNICEF assistance was initiated in one state in India.

Penicillin for these projects comes from abroad. Governments have with difficulty met substantial costs of such supplies. The establishment of a penicillin plant in India, with assistance from WHO and UNICEF, is a step towards making such supplies more available in that country. The cost of penicillin is still a grave deterrent to large-scale control programmes. In the control both of venereal diseases and of yaws, laboratory services are vital. In one instance, a laboratory was developed into a public health laboratory offering free services to the medical profession and the public. The simplified serologic technique in use in the Region has made it possible to cover more of the population.

In March 1952 an international yaws symposium was convened under the auspices of WHO and UNICEF in Bangkok, at which eminent workers from almost all parts of the world considered such questions as optimum dosage, treatment of contacts, re-surveys, and organization of mass campaigns. To test the efficiency of the new amino salts of penicillin in the treatment of yaws, a bicillin® estimation test was begun in Indonesia in November. The first part of the test will be an evaluation of the duration of therapeutic penicillin blood levels in patients doing various degrees of manual work after a single injection of the drug. A clinical trial large enough to be of statistical significance is also under way.

Leprosy is endemic in all the countries. In Burma, after a survey in 1951, a WHO specialist has started to organize a leprosy service. In Ceylon, also as a result of a WHO survey, assistance has been requested, and provision has been made for an international team consisting of a leprologist, a pathologist, and an occupational therapist to work there for two years.

An inter-regional rabies conference and seminar for the Eastern Mediterranean, Southeast Asia, and Western Pacific Regions was held at Coonoor, India, in July 1952, with discussions and demonstrations of laboratory procedures and of diagnosis and treatment. It was attended by 38 Fellows from the three Regions, eleven leaders, and seven observers.

The usual epidemiologic and vital statistics reports and returns were received. A WHO consultant visited the countries in this Region to recommend how governments could be assisted in developing their health and vital statistics, and at the end of the year his report was receiving consideration. A statistician from headquarters who went to Afghanistan in September submitted proposals for improving the vital and health statistics in that country. Negotiations were started with the Government of India for modifying the course in statistics at the All-India Institute of Hygiene and Public Health, Calcutta, so that it may answer to the regional needs for training in public health statistics.

Dr. Hy Li, WHO yaws specialist, in laboratory (Jokja, Indonesia), looking into microscope and reading VDRL tests.

The construction of the penicillin factory in India was proceeding well at a site at Pimpri near Poona, in Bombay State. The buildings will be ready to receive equipment early in 1953. The technical advisers provided by WHO arrived and the task of choosing national personnel was well advanced. A suitable training programme was developed, which will provide both scientific training and equally essential training in production. A manual of operating instructions was being prepared.

An order for the equipment required for the establishment of a DDT plant in Ceylon was placed by UNICEF in February. Part of this equipment was manufactured, and many items were ready for shipment, but there was some delay in construction. Arrangements for the setting up of the Indian DDT plant, making use of the industrial facilities already existing in Delhi, are going forward quickly. International personnel to guide the construction work and to supervise technical aspects were provided.

A medical supply officer was appointed about the middle of 1952 to supervise the technical side of the procurement of supplies and equipment for field projects. Requests for the purchase of items totalling $235,000 were received and processed for procurement from abroad. More and more equipment and supplies are required by the countries of the Region; and it was not always possible to approach bilateral agencies.

EASTERN MEDITERRANEAN REGION

The strengthening of public health administrations and the improvement of training of health personnel were the main items in the programme of assistance to countries during the year, although the Regional Office also provided help in bridging specific gaps in health services and in emergencies calling for special action.

Various means of strengthening public health administrations were adopted. First, WHO appointed advisers to governments. It proved difficult to recruit public health administrators of suitable calibre; however, one was appointed to Ethiopia during the year. In 1951 an adviser had already been assigned to Libya, another to Iran, and a third to Jordan, Lebanon, and Syria, so that by the end of 1952 advisers were working with six of the governments in the Region. In 1953 it is planned to provide "country representatives" in some countries, rather than advisers to governments. Second, 22 fellowships were granted to physicians and nurses for training in public health. By developing health demonstration areas in rural districts WHO attempted to show how health and welfare services may be integrated. In 1952 preliminary surveys for such areas were made in Lebanon, Iraq, Iran, and Pakistan. WHO also planned the development of urban health centres to show how the different parts of a city health service may be integrated and linked with other WHO–assisted projects in the same places.

The lack of trained personnel of all grades has been one of the main obstacles to progress in public health, and emphasis has accordingly been placed on training in most of the field projects in the Region. All the projects in maternal and child health, rural health, and the control of malaria and venereal diseases were developed both to demonstrate modern methods and to provide facilities for training. Specific training projects were also started, such as the projects for the training of nurses in Iran and Israel. WHO helped with the development or establishment of national training facilities. It gave assistance to medical schools in Pakistan, and provided lecturers: one on parasitic diseases to Iraq, and another on preventive medicine to the French University of Beirut. The Organization also helped with postgraduate training in the Malaria Institute in Iran, made plans to assist training in basic nursing in Egypt, Iran, Israel, Jordan, Lebanon, Libya, Pakistan, and Syria, and awarded regional and interregional fellowships.

The wide variation in educational facilities in the Region, with some countries possessing well-established universities for graduate and postgraduate education while others have no facilities for training even medical auxiliaries, makes it necessary, both in awarding fellowships and in helping training institutions, to provide assistance on three different levels: to train (1) teachers and administrators, (2) fully qualified doctors, nurses, public health engineers, and sanitarians, and (3) health auxiliaries. During the year 131 fellowships were awarded. The training of auxiliary health staff was promoted in maternal and child health centres and through fellowships to the American University at Beirut, which organized special courses for sanitary inspectors, laboratory technicians, and public health nurses under the direction of a WHO public health administrator.

Consultants were sent to advise on the epidemic of cerebrospinal meningitis in the Sudan; nursing instructors were assigned to midwifery schools in Iran; and advice was given and surveys carried out in connection with the establishment of a rehabilitation centre for immigrants in Israel and with a similar rehabilitation project for crippled children in Lebanon.

Interest in the control of malaria is steadily increasing. With assistance from WHO and UNICEF, Egypt made plans to build a DDT plant, and will open, with the help of WHO, a training centre for Arabic-speaking malariologists, entomologists, and sanitary inspectors. Iran and Pakistan, assisted by the Technical Cooperation Administration (TCA) and UNICEF respectively, are continuing, with advice from WHO, intensive work in malaria control, which has earned great praise and has been of considerable value to these countries. WHO-assisted projects were also continued in Lebanon and were begun in Saudi Arabia, in Syria, and in the Tanjero valley of Iraq during the year. The regional malaria adviser surveyed the malaria problem with a view to the drawing up of a control project.

In the regional work on tuberculosis, it was agreed that every project should include a laboratory, that BCG campaigns should form a part of such projects, and that a manual should be prepared on the technique of making simple bacteriologic and epidemological investigations. It was decided, moreover, that statisticians should be appointed to assist with projects in tuberculosis control, including campaigns for BCG vaccination. A special research team from the Tuberculosis Research Office, Copenhagen, investigated the variations noted in the results obtained in the Region. During the year, the programme of BCG vaccination was completed in Aden and turned over to the government; the programme in Pakistan, considering the shortage of team personnel, progressed satisfactorily; the campaign in Egypt was about to terminate at the end of the year; BCG programmes were started in Iran and Iraq, and others were planned for Libya and the Sudan for 1953. Tuberculosis demonstration and training centres were opened in Egypt and Syria, and WHO's assistance to the centre in Pakistan will be prolonged into 1953. The building of the tuberculosis centre in Iraq, which had suffered some delay, was going forward at the end of the year; arrangements for opening a centre in Israel early in 1953 had been completed, and a programme including BCG vaccination and a tuberculosis centre in Ethiopia had been planned for 1953.

Training and demonstration centres are greatly needed through the Region if the health of mothers and children is to be improved. Special attention was given to the training of midwives, public health nurses, and auxiliaries, and, because of the extreme shortage of nursing staff, several projects had for their primary objective the training of community midwives, for whom courses were arranged. Demonstrations and refresher courses were arranged for all categories of medical personnel, including general practitioners, medical students, and student nurses. Demonstration centres for maternal and child health were opened during the year in Beirut, Lebanon, in Damascus, Syria, and in Peshawar, Pakistan. The Lahore project in Pakistan was fully active throughout 1952. Other centres were planned and will soon be opened in Baghdad, Iraq, in Dacca and Karachi, Pakistan, and in Teheran, Iran, and similar projects were well advanced for Libya and Jordan. WHO also sent a team to assist in the training of nurses in Iran. In most of the projects UNICEF has given assistance by providing equipment and supplies.

Assistance was given to schools for training nurses in Syria and Israel, and plans were made to establish training centres in Libya and Ethiopia. Nursing advisers were provided for Libya and Iran. Such advisers have been working for some time in Lebanon and Syria and the usefulness of their services is appreciated.

The two treponematosis programmes which were in operation during the whole of 1951—the demonstration of control of venereal diseases in Egypt and the bejel-syphilis project carried out in Iraq with assistance

from UNICEF—were continued throughout 1952. The former finished at the end of the year, but the programme in Iraq will, at the request of the government, be extended throughout 1953. In June, an advisory team on the control of venereal diseases began to operate in Ethiopia; towards the end of the year another began work in Saudi Arabia, and a demonstration centre was opened at Karachi, Pakistan. Plans were made for WHO's assistance with a bejel-syphilis campaign due to begin in Syria early in 1953.

Surveys of the incidence of leprosy and demonstrations of modern methods of treatment were started in Ethiopia in February. A plan for another such project, to start in April 1953, was submitted to the Government of Iran for approval.

In environmental sanitation WHO's attention was directed mainly to a survey of the problems affecting the Region and to the development of training programmes. In connection with this survey the regional adviser visited Egypt, Jordan, Lebanon, Libya, Pakistan, Turkey, and Syria. The sanitarian is, in fact, an indispensable member of almost every project of the Region. There is immense scope for work in food hygiene in the Region, and requests were received and plans made, in collaboration with FAO, for a consultant to be sent to Egypt and Syria. The greatest need, however, is to organize and develop the training of sanitarians, public health engineers, and auxiliaries.

The services of a headquarters consultant on health education were placed temporarily at the disposal of the Regional Office during the year. This consultant visited Egypt, Jordan, Lebanon, and Syria to study health education programmes and to stimulate interest in the regional centre for training in fundamental education at Sirs el Layan in Egypt, a project sponsored by UNESCO in which WHO is co-operating. During the year a meeting was held with UNESCO on the part to be played by WHO in the project, and it was decided that it should become a fundamental education centre sponsored jointly by the two organizations.

In the Eastern Mediterranean, trachoma is a perennial problem; in Egypt alone the disease is estimated to be the cause of 70 percent of all blindness. Since the advent of sulfonamides and antibiotics, a regional campaign against trachoma has been under consideration. Information was obtained from the work carried out among Palestine refugees by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWAPRNE) and from the deliberations of the WHO Expert Committee on Trachoma, which met in Geneva in March. The main difficulty remains that of ensuring over an extended period in a mass campaign the correct and regular application of the modern drugs recommended.

The regional survey of bilharziasis started in 1951 was completed by surveys in Ethiopia (including Eritrea), Iran, Iraq, British Somaliland, Somalia, the Sudan, Syria, and Yemen. The two consultants submitted reports for consideration by the Regional Office and the governments concerned. Towards the end of the year a scheme for the control of bilharziasis was put into operation in Egypt; a similar scheme was being planned for Iraq and plans were agreed on for a project in which bilharziasis and malaria control are combined, to be carried out in Syria in 1953. Field trials of new molluscocides are still in progress in Egypt.

For the inter-regional rabies conference and seminar held at Coonoor, India, in July, under the sponsorship of WHO, 15 fellowships were awarded to representatives from countries in the Eastern Mediterranean—three of them to Turkey, then still a member of the Region.

A consultant completed surveys in mental health in Egypt and Iraq in the early part of 1952 and in October another consultant made a similar survey in Jordan. The resulting reports were being considered by the governments concerned at the end of the year. In December a meeting held in the Regional Office to plan the mental health seminar proposed for late 1953 was attended by representatives from Egypt, Iraq, Lebanon, the Sudan, and Syria, by the two consultants mentioned above, and by members of the Regional headquarters staff.

Thirty-four agreements with governments for assistance from the Technical Assistance funds or under the regular programme were signed. Assistance to Palestine refugees was continued.

EUROPEAN REGION

Since the countries of Europe are generally at a stage of technical development permitting advances in a large number of health fields, it was necessary, early in the life of the Regional Office, to lay down a set of principles for the action of WHO in Europe—the most suitable ways in which international help could be given. At the second session of the Regional Committee, it was agreed that the Organization's most important roles were the co-ordination of policies on common health problems, the exchange of information, the study of different patterns of health services, and the promotion of professional education and training. The further role of giving direct assistance to countries economically retarded was related to these without too much difficulty.

Any description of what has been done along these lines in a single year must be considered in conjunction with the information in previous reports. WHO continued to participate in the work of European countries on alcoholism, anaesthesiology, antibiotics, diseases of children, environmental sanitation, handicapped adults, health visitors, homeless children, malaria, mental health in childhood, occupational health, premature infants, preventive medicine, public health administration, public health training, social casework, social paediatrics, thoracic surgery, and venereal diseases which are part of the steps in the continuous development of health programmes in Europe. For instance, the International Anti-Venereal Disease Commission of the Rhine established in 1950 to control venereal diseases among Rhine River boatmen and their families is composed of Belgium, France, Federal Republic of Germany, Netherlands, and Switzerland.

Regular Programme. Programmes financed by the regular budget have included some studies in broad medico-social fields, such as the study of the needs of the family now being conducted in England and France. Some work has also been started in such more special technical fields as the psychologic development of the child. Much more will need to be done in the future to study problems in this way before embarking on international action.

The co-ordination of health policies has involved thus far the establishment of one regional commission, the International Anti-Venereal Disease Commission of the Rhine mentioned above, and this type of activity, too, requires development.

During the year, regional technical conferences, seminars, and so forth, were conducted on a wide variety of topics. In Europe such programmes have now advanced to a point where it is becoming urgently necessary to define terms such as "seminar," "study group," "symposium," and "training course," and to state clearly the objectives of bringing health personnel together around a conference table, a point emphasized by the Regional Committee. A technical conference or a seminar has an immediate impact on the participants which is usually appreciable. In addition it offers opportunities to bring professional groups together as a

team, as for example public health engineers with public health officers, industrial health officers with public health officers, paediatricians with child psychiatrists, and medical officers with veterinarians. To estimate the long-term value of such activities is less easy, but there was evidence during the year that seminars and conferences were being planned by governments on a national level to follow up those sponsored jointly by a number of countries.

Professional education and training continued to be basic to the European programme. Group training courses, assistance to public health and other training institutions, and individual fellowships have all been complementary parts of the same programme, the broad objectives of which were set out in the Annual Report for 1951. Like regional conferences, group training offers opportunities for assembling a team of health personnel, each member of which is responsible for special aspects of a total programme—for example, the management of the physically handicapped child. In order to evaluate the results of group training it is necessary to estimate the ability of the individuals so trained to function together as a team after the internationally sponsored training course is completed. Also, several types of training are included in the term "fellowship," and there is a need for a standard terminology to differentiate between the various activities under this heading: individual or group studies designed to provide basic undergraduate or postgraduate training, and short study tours or participation in conferences, seminars or symposia.

Sets of the Yale University *Abstract Archives of Alcohol Literature,* which consist of abstracts printed on coded and punched cards and dealing with all aspects of the problem of alcoholism, were ordered at their request for Belgium, Denmark, Finland, France, Germany, Ireland, Norway, Sweden, Switzerland, and Yugoslavia.

Technical Assistance Programme. The programmes in Europe financed by Technical Assistance funds are naturally less extensive than in other Regions, but such programmes were in full operation during the year in Yugoslavia and were starting in Austria, Finland, Greece, Turkey, and Spain. Most of these programmes were planned within a broad public health framework, international assistance being given to certain elements. Europe offers particular possibilities for integrated activities of this kind not only within national health programmes, but also in relation to the international assistance provided by ILO, FAO, and other interested agencies.

In 1952 programmes have been continued in the control of communicable diseases, in mental health, in public health administration, and in maternal and child health, while a new feature in the year has been the developments in occupational health which are essential to the advancing industrialization of many European countries. Work in environmental sanitation has expanded to include preliminary studies of a number of topics arising out of the annual conferences of public health engineers, such as the development of a glossary of agreed terms and studies of standards of water purity. Preparations were also being made for a symposium on insect control and for specialized training in such subjects as insect control, food sanitation, and waterworks management. Nursing has suffered from activities of too sporadic a character, a tendency which it is hoped will be corrected by the appointment of a health officer for this subject in 1953; good progress was made, however, towards convening a second conference of European nurses for 1953, and some improvement took place in facilities for the training of nurses both in groups and by the award of individual fellowships. Health education of the public is now an integral part of many of the Technical Assistance programmes, and the first conference of European health educators was prepared during the year by a consultant specially engaged for the task.

Medical library organization has hitherto received insufficient attention in programmes for assistance to national training institutions. Considerable progress was made in remedying this situation during the year, particularly in countries which had requested this service as part of the Technical Assistance programme. Small libraries were provided wherever appropriate, in conjunction with group training courses and seminars, a service highly appreciated by the participants.

WESTERN PACIFIC REGION

The primary objective has been to help to meet the most pressing health needs within the general policy and principles adopted by the Organization. Only in a few countries were there long-term health programmes in which the Organization could assist. From the assistance being given it has been possible to observe certain general trends. For example, there were more projects of assistance in nursing than in any other subject; and programmes for the control of tuberculosis and malaria were also numerous. An interesting point in the malaria projects was the help given to two countries in field research work, and field research has also been a feature of the bilharziasis project in the Philippines. A recent development has been the increasing attention given to environmental sanitation. Health education of the public was a part of many projects; one programme of training in this subject was begun during the year, and a lecturer was provided for the University of Malaya.

In Cambodia, Korea, Laos, Malaya, the Philippines, and Viet Nam, health work was hindered by political disturbances ranging from minor disputes to open conflict. Another factor affecting the work of governments and the Organization is the geography of large parts of the Region, where small communities live on tiny islands often far from other islands and even farther from the mainland.

Considerable effort was required to recruit personnel with the requisite qualifications. Although for certain categories numerous applicants were available, there has seldom been a large choice of candidates possessing all the qualifications desired. The dearth of suitable people has in many instances delayed the implementation of such projects as those in nursing, for which at the end of the year 22 instructors were required, only 13 of whom had been recruited.

Tuberculosis work, particularly in BCG projects, was accelerated. In consultation with the governments and with UNICEF, WHO helped to plan BCG campaigns for Brunei, Cambodia, North Borneo, and Viet Nam, and work on some of these projects started before the end of the year. A mass campaign was started in Sarawak, and another, begun in the Philippines at the end of 1951, was continued. Campaigns were completed in Taiwan and Hong Kong.

The Alabang Laboratory near Manila, which received the approval of WHO as a BCG production laboratory, is producing sufficient vaccine not only for the campaign in the Philippines but for export to Hong Kong and Taiwan. The BCG laboratory of the Pasteur Institute in Saigon was also approved by the Organization; its vaccine will be used in Cambodia and Viet Nam. Under a director who had completed a WHO–sponsored study tour in the United States of America, Europe, and the Philippines, the laboratory at Taipei also started production, and it was arranged that a WHO-BCG consultant should inspect it. The same consultant will also visit Japan, where BCG is produced on a very large scale. For the Malaya and Singapore

campaigns, the vaccine produced in Madras was used.

Although most of WHO's advisory work on tuberculosis was in connection with BCG campaigns, an increasing amount of assistance to governments in other aspects of tuberculosis control (such as surveys, treatment, work in dispensaries, and thoracic surgery) was discussed.

Malaria is still a major public health problem in the Region except in the far north and far south and in those Pacific islands where Anopheles mosquitoes are not found. During the year, WHO assisted in malaria and insect control projects in Cambodia, the Philippines, Sarawak, Taiwan, and Viet Nam. The projects in Cambodia and Viet Nam are continuations of those described in previous annual reports. In May, a four year project was started in Taiwan with the eventual purpose of eradicating malaria from the island. In the malaria projects in the Philippines and Sarawak, the principal objective is to determine whether or not *A. minimus flavirostris* and *A. leucosphyrus* can be controlled by the use of residual insecticides. If they can, the economic consequences of the findings will be considerable. In both projects the international teams are training as many local workers as possible in order to ensure the continuation and expansion of the work after the withdrawal of WHO personnel. In many countries of the Region the use of residual insecticides for the control of malaria has not been considered so successful as in most other parts of the world. For this reason, projects in the Western Pacific were largely concerned not with demonstrating the use of residual insecticides but with determining their effectiveness.

During the year, three short-term consultants in venereal diseases and treponematoses were engaged, and a specialist from headquarters made a short visit to the Region. The Governments of Hong Kong, the Philippines, and Taiwan were advised on the improvement of their venereal disease services, and in Taiwan a plan of operations was prepared for a control demonstration, which will be carried out with the help of WHO and UNICEF. Another plan was prepared with the Government of Laos for a project to control yaws in the provinces of Pakse, Saravane, Savannakhet, and Takhet. In the Philippines it was recommended that the mass yaws campaign be extended, and plans for this expansion were made with UNICEF.

Work in ophthalmology was started. A short-term consultant, engaged to assist in preparing a plan of operations for the control of trachoma in Taiwan, also gave advice to the Government of Hong Kong, investigated conjunctivitis in the Philippines, and visited Sarawak towards the end of the year to advise the government on the development of ophthalmologic services.

Although several of the quarantinable diseases are prevalent in the Region, plague is the only one that has been the subject of a request for assistance. Taiwan has asked that a consultant in plague control should study this subject in the Kinmen Islands, but because of the difficulty of recruiting such a consultant a fellowship was granted to enable a local physician to study plague vaccine production and methods of rat and flea control in Hawaii and India.

Studies on bilharziasis were made during the year. *Schistosoma japonicum* is found in Celebes (Southeast Asia Region), Japan, the Philippines, and Taiwan, but the problem varies in the different countries. In Taiwan man has not been known to be infested; in Japan there is reason to believe that bilharziasis can be effectively controlled by the use of molluscocides, but in the Philippines the evidence of their effectiveness is as yet insufficient to justify using them, and field research has therefore been started.

The governments of many countries in the Region asked the Organization to assist them in the training of

The Government of the Philippines has launched a nation-wide campaign against TB. Dr. Gerzer (center), WHO specialist, with Dr. Simpson, Department of Health, watch nurse test child.

nurses. The assistance already being given by WHO to the schools of nursing in Malaya and North Borneo, as described in last year's report, was increased by the assignment of more WHO nurses to the teaching staff. In addition, several new projects in nursing education were started: in Brunei a nursing instructor helped to start a training programme for assistant nurses; in Cambodia a team of nursing instructors and a specialist in maternal and child health helped the government to establish the first school of nursing in that country and to develop a training programme for midwives and public health nurses; additional staff were assigned to Taiwan to assist in strengthening nursing education and developing training in public health nursing; and a midwifery instructor was assigned to Singapore to advise on the development of a midwifery teaching programme.

The first seminar on nursing education to be held in the Western Pacific was organized in Taiwan in November. This seminar, sponsored by WHO under the Technical Assistance programme, was attended by 29 nursing instructors from 12 countries. The workshop method was recognized as a new and effective way of teaching. The active participation of the host government and the co-operation of UNESCO and UNICEF were most valuable, and the interest and enthusiasm of the participating governments and the nurses who attended will be valuable in planning future nursing seminars.

During 1952 progress was made, in conjunction with UNICEF, in a number of projects in maternal and child health. In Cambodia and Viet Nam plans were prepared for maternal and child health centres, a paediatric ward, nursing and midwifery schools, and the provision of equipment (the project in Cambodia was an enlargement of the demonstration project started at the end of 1951). A programme in maternal and child health was begun in Taiwan, and advice and

assistance on the care of premature infants were being planned for Japan. In Hong Kong, plans were made to start a project early in 1953. Projects for maternal and child health were thus initiated in two countries during the year, an important development in the activities of the Region.

In addition to the nursing seminar already described, the Regional Office also arranged a seminar on vital and health statistics in Tokyo with the co-operation of the United Nations and the Government of Japan. This seminar gave additional practical training to workers in statistics from eight countries in the Region.

The inter-regional seminar and working conference on rabies held at Coonoor, India, was attended by ten participants from five different countries in the Western Pacific. Other regional conferences at which participants from the Western Pacific were present were the yaws symposium at Bangkok, Thailand, and the seminar on mental health and infant development in Chichester, England.

During the year 63 individual fellowships and 53 fellowships for group training were awarded to applicants from 17 countries and territories; of these 43 were provided under the regular programme and 73 under Technical Assistance.

Assistance in public health training was given to the Universities of Malaya and the Philippines, and considerable attention was devoted to the development of teaching facilities at both these institutions.

HEALTH SERVICES FOR SPECIAL GROUPS

During 1952, in addition to the assistance given to governments, WHO continued to provide health services to special groups at the request of the United Nations: the Palestine refugees under the care of the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWAPRNE), and the civilian population of Korea.

In 1952 WHO completed its fourth year of collaboration in the Palestine refugee programme, in which more than 850,000 refugees in Lebanon, Syria, Jordan, and the Gaza area have been cared for.

In July 1952 the United Nations Korean Reconstruction Agency (UNKRA) asked WHO to send a mission to the Republic of Korea to prepare, after consultation with the government, a plan for the rehabilitation of its health services. Two other specialized agencies, FAO and UNESCO, also sent missions to make proposals on certain aspects of rehabilitation. Since the three agencies have some common interests, particularly in nutrition and in medical education, the missions found it expedient to consult together occasionally.

During its three months in Korea, the WHO mission visited almost all the accessible parts of the country, and maintained the closest possible contact with Korean officials and health workers, with whom problems were freely discussed.

The report of the mission is concerned only with the principles and outlines and leaves the details to be filled in by those who will carry out the work. The proposals are designed to place public health and medical services on a stable footing by the end of a five year term of reconstruction.

Fellowships. The year 1952, the sixth in which the World Health Organization carried on a fellowship programme is notable because the number of fellowships granted was larger than in any of the previous years. A total of 1,147 awards were made, as against 662 in 1951.

PICTURE CREDITS

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Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

EDITORIAL SECTION

NATIONAL CITIZENS COMMITTEE FOR THE WORLD HEALTH ORGANIZATION

RECOGNIZING that the World Health Organization, one of the specialized agencies of United Nations, is of particular interest to all engaged in the field of medicine, the editors of the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION have annually since 1948 published a special number in which the activities of WHO have been described. This, the July number of the JOURNAL, perpetuates the precedent established five years ago. The report of the Director-General, which has been summarized for this publication, is a testimonial to the effectiveness of international co-operation by which many millions throughout the world are now experiencing the benefits of improved personal and public health.

On a recent trip through the East it was our privilege to visit many of the projects of World Health Organization—the Tuberculosis Training Center in Istanbul, Maternal and Child Health Services in rural India, Malaria and Yaws Control in Thailand, the Rural Health Demonstration in the Philippines—to mention only a few. Surely the indifference and opposition toward the United Nations which exist in some quarters would vanish if there were keener realization of the misery in which millions are dwelling today and of the importance to our own well-being of raising the standards of living in these underdeveloped countries.

The need of an enlightened public opinion toward the importance of international health work has been discussed since the days of the Interim Commission which preceded WHO and also after WHO was formally launched in September of 1948. To meet this need a National Citizens Committee for WHO has been formed under the joint sponsorship of the American Association for the United Nations and the National Health Council. A National Conference on World Health was held in Washington, D.C., April 6, 7, 8, 1953, attended by representatives of 178 interested organizations and agencies. Plans for individual and organization membership were studied, objectives formulated, and methods outlined.

> "The purpose of the National Citizens Committee For The World Health Organization is to acquaint our people with the relationship of public health to the general welfare and peace in all parts of the world community, and to increase appreciation of the importance of international health programs. The Committee will also discuss and make known the constructive work which WHO is now doing and plans to do in the future. The Committee will endeavor to help in the task of eliminating apathy and opposition to the United Nations and its Agencies which stem from ignorance and lack of concern.
>
> "The intention of the Committee is to reach a significant number of the American people, school children and adults, and help them to recognize the relationship between the health of people of other countries and their own health and well-being—also to appreciate the favorable effect that joint efforts for better world health may have on our chances for world peace.
>
> "Health educators in the United States have shown considerable success in bringing people to realize the inter-relationship between their own health and the health of others in their community, in their state, and in the nation. The need now is to help the individual broaden his awareness to a still wider horizon—the rest of the world."

We who are concerned with the art and science of healing have a special responsibility in furthering an appreciation of the importance of international health programs, for no individual can be safe as long as disease prevails in any part of the World Community. Consequently the National Citizens Committee For The World Health Organization deserves our wholehearted support. Much has been accomplished by WHO: much remains to be done. Poverty, illiteracy, and disease must be eliminated and physical, mental, and social health standards must be raised if we are to live in a happier, healthier, and more peaceful world.

ADA CHREE REID, M.D.

Pioneer Medical Women of Switzerland

HALF WAY DOWN the slope between the lake and the woods crowning the top of the Zurichberg in Zurich, largest city in Switzerland, is situated a famous modern private hospital called Schweizerische Pflegerinnenschule und Krankenhaus (Swiss school for nurses and hospital). Built at the beginning of the century, this hospital has developed rapidly in size and reputation. Today, modernized and enlarged to keep pace with the advance of medical hygiene and techniques, it contains a surgery, a midwifery, and a gynaecological department as well as sections for children, for the treatment of internal diseases, and a radiological department.

This hospital was founded by women. It owes its existence to the combined initiative of the officials of the Schweizerische gemeinnützige Frauenverein (Swiss women's welfare association), two Swiss women doctors, and a nurse. The strongest personality among these women was Dr. Anna Heer who was ably supported by Dr. Marie Heim-Vögtlin, the first woman doctor of Switzerland, and Oberin Ida Schneider, matron of the hospital.

Dr. Marie Heim-Vögtlin was born in 1845 in a little village in the canton of Aargau. With her sister she received private lessons from her father, a clergyman, and from another clergyman, a friend of the family and an excellent teacher. A year spent far from home in French Switzerland enlarged her knowledge. Later in the small town of Brugg, the new parish of her father, the young girl helped in the small hospital as well as in a school for poor children. She became engaged to a young doctor relative but after a short time the engagement was broken.

Marie Vögtlin wanted not only to be a doctor's assistant but also to become a doctor herself. In the year 1868 she began to study medicine at the University of Zurich, the first in Switzerland to admit women students, although the idea that a lady should go to a university was at that time considered quite extraordinary. There were among her fellow students an American, Susan Dimock, who later became a doctor in the Children's Hospital in Boston, and two English students, Frances Elizabeth Morgon and Eliza Walker.

In 1874 Marie Vögtlin finished her studies in Dresden, returned to Zurich where she took her degree and so became Switzerland's first woman doctor. She began to practice at once. In the following year she married a professor of the Polytechnical School, Albert Heim, to whom she had become engaged when she was a student. The young couple worked hard devoting themselves wholeheartedly to their profession. Dr. Marie Heim used to rise at five o'clock every morning during the summertime and at six o'clock in the winter, otherwise she would not have been able to get through her work which included household duties in addition to the visits to patients and consultations in her crowded surgery. Husband and wife never saw each other except at meal times and in the evening when they would sit at their double writing desk and talk together for a few minutes before settling down to deal with the enormous amount of written work awaiting them. Sometimes the husband could not help wishing that he himself were ill, so that his wife could attend to him and be near him. He indeed made many sacrifices to give his wife the opportunity to devote herself to her career.

When their children started to arrive, Dr. Marie Heim-Vögtlin had to spend a good deal of her time on their education. Nevertheless she continued to look after a limited number of patients and she never tired of helping a poor woman, especially the poor hardworking mothers, for whom she had the greatest sympathy and respect. A part of her medical work was done in the newly opened Schweizerische Pflegerinnenschule. She was in charge of the children's department. At the same time she instructed children's nurses and she also dealt with the administration of the hospital. From 1901 until 1916, the year of her death, she carried on this work. She was the most valuable co-worker of the doctor-in-chief, Dr. Anna Heer.

Dr. Anna Heer was born in 1863 in a small town on the Aare-river. She was the eldest daughter of the owner of a little shoe factory. She attended school in Aarau and, being very gifted, she was always at the head of her class. With a friend she took Greek lessons to enable her to read Homer in the original. She loved drawing and, when 17 years of age, she went to Zurich to study painting. But soon she felt that her vocation lay in another direc-

DR. ANNA HEER

DR. MARIE HEIM-VÖGTLIN

tion and accordingly she changed her subjects of study to pass the entrance examination for the university. After five years' study she received her diploma in medicine, which enabled her to practice anywhere in Switzerland. Then she prepared herself for the degree of a medical doctor which required a thesis to be written on a particular scientific subject. She passed the examination with the highest distinction. But she still wanted to improve her knowledge in social medicine, midwifery, and gynaecology and to this end she visited the clinics of Tübingen and Freiburg in Germany and later did medical service in a polyclinic in London. On her return she began to practice in Zurich. In a short time, she was one of the city's most renowned and sought after doctors. After long hours in the consulting room, she would go out to visit her bedridden patients, not forgetting to put a little candle and matches in her bag so that she could find their homes at night. Despite this exhausting programme, she nevertheless found time to teach hygiene in the City College for girls.

Doing her practical medical work from early morning until late at night, Dr. Anna Heer felt more and more the lack of trained nurses. Indeed there were Catholic and Protestant sisters but their number was not sufficient to meet the demand. The idea of founding a nurses' school and at the same time a hospital for the purpose of practical training arose in Dr. Anna Heer's mind. She found a ready response to her appeal among the Swiss women and from the public in general. The Schweizerische gemeinnützige Frauenverein helped her to realize her ambition. In 1899 the foundation stone was laid, and in 1901 the inauguration of the hospital and of the nurses' school took place. Dr. Anna Heer was elected chief doctor having three women doctors as her assistants, among them Dr. Marie Heim-Vögtlin. The matron was Ida Schneider. The course for the nurses was modeled after the English method, whereas the housekeeping was similar to that in German hospitals. The first patient was not the expected woman coming in for childbirth, but a little boy suffering from appendicitis, who had to be operated on at once. From 1901 to 1918 Dr. Anna Heer was head of the Pflegerinnenschule and under her practical leadership both the hospital and the nurses' school gained a remarkable reputation for efficiency and service. In 1918 she died in the fifty-sixth year of her life after only a month's illness which was caused by an infection she had contracted in the course of her work.

The Swiss women doctors esteem highly the names of Anna Heer and Marie Heim-Vögtlin, for they have cause to be grateful to these two pioneers, who together proved as noble-minded as they were skillful and who took upon themselves the heavy task of fighting for the recognition of women doctors in the national life of Switzerland.

ILSE SCHNABEL, M.D.

Women Surgeons in India

INDIA IS A LAND of unlimited opportunities for medical women. There is literally no end to the openings and possibilities for well-trained doctors in that large subcontinent. With the enormous shortage of doctors, 50,000 of them for 350,000,000 people, and the vast amount of preventable and curable illness, it is no wonder that a conservative estimate, made by a government planning committee, puts the number of doctors needed at 250,000. The actual number of women doctors is small, probably not more than 2,000. With only 7,000 trained nurses in the entire continent, it is clear that the medical education of women lags behind even that of the men. Yet women doctors are needed in India, more than almost anywhere else. The traditional modesty and strict seclusion of the women, both Hindu and Mohammedan, keeps them away from male doctors, especially male surgeons, gynecologists, and obstetricians. Statistics are hard to compile, but anyone who has done medical work in India knows from experience that large numbers of young and middle-aged women with tumors, chronic pelvic inflammations, childbirth injuries, even vesicovaginal fistulas, go untended for many years, sometimes for a lifetime, simply because they can find no woman doctor to care for them.

This is one of the reasons why medical mission work in that country is so important and so much in demand. Every town, every province, every county needs hospitals, particularly for women. Beautiful buildings and expensive equipment are not the first requirements, though adequate working facilities are necessary. Above all these hospitals need well-trained and keenly interested staffs. Provided that requirement is filled, all the rest will follow. Patients will flock to the hospital, no matter how simple and how distant. Not only will the poor come, but also the middle classes and even the wealthy. They will spread its fame over the countryside, and each cure will be the nucleus for an ever-growing number of patients. Good medical and especially good surgical care is at a premium in India. Well-to-do women are to live in strictest "purdah" (seclusion), and so they are even more dependent on women doctors than others.

This is not mere theory as the Medical Mission Sisters of Fox Chase, Philadelphia, know. One of the best illustrations is their Holy Family Hospital in Mandar. Situated about seventeen miles from Ranchi, the summer capitol of Bihar, in the heart of India, this hospital started out with three small buildings, one ward for men, one for women, and a one story building housing the operating room, an outpatient department, and a few private rooms. In six years it has grown to 100 beds, in five different buildings, several of them two stories high. The hospital is surrounded by rice fields and scrubby jungle, but it is rapidly becoming the center of a small village, with a mission church, grade school, foodshops, and "hotels" Indian style. All day long busses, trucks, oxcarts, and rickshaws trundle through the hospital gates, bringing patients from ten, twenty, a hundred miles. Each patient is accompanied by an entire family, and one relative will stay with him or her during the entire hospital stay, to fan and massage, to fetch and carry, to cook the food, and fix the "pan" (betelnut) for chewing. The average census is around ninety and consists of men, women, and children, with every ailment under the sun represented.

All this is not a matter of bricks and supplies. It takes people to build up institutions. The first doctor to arrive in Mandar was Sister M. Barbara Taggart, M.D., a graduate of Woman's Medical College of Pennsylvania (1943). Sister Barbara had had the advantage of a surgical residency in St. Joseph's Hospital in Baltimore, Maryland. During the war women interns and residents had their chances at surgery, and Sister Barbara made good use of her opportunities. When she came to Mandar, in the spring of 1947, she soon found herself plunged into an exhausting schedule of operations. Everything she had ever learned, many things she had only heard of, and quite a few situations she had never met before, had to be handled and cared for, simply because there was no one else to do it. Tropical diseases, hopelessly neglected cases of obstructed labor, complicated injuries, outbreaks of smallpox in nearby villages, everything seemed to happen at once. People in the countryside learned that medical and surgical care were available in Mandar, and the sleepy "bend in the road" became a meeting place for the sick. "You seem like gods to us," said a man to her, one day. "What did you do before we came?" asked Sister. "We died," was the simple answer.

Through the years that followed, surgery became the most important specialty. Infectious diseases were common and serious, especially typhoid, malaria, the dysenteries, and tuberculosis, but the new drugs are making the treatments much easier and

shorter than before. Obstetrics never assumed very large proportions, because the women of that neighborhood prefer to have their babies at home. Most are delivered by untrained midwives. There is no substitute and no short cut for surgery. The wards are full to overflowing, and there is always a waiting list of elective cases. Gynecologic work comes first. Fibromyoma of 10 or 15 years' standing are nothing unusual. Vaginal and perineal repairs have their seasons, when the harvest is in, and the family has time and money to spare to get its womenfolk fixed up again. Especially gratifying are the cases of vesicovaginal fistula. Life with complete urinary incontinence is hardly worth living, yet these women often drag out such an existence for many years, before they get help from surgery. Transplantation of ureters, now that the antibiotics are available to control infection, has a much better prognosis for prolonged survival. Some of these patients have even had babies later, by cesarean section of course.

General abdominal surgery also is in great demand. Sister Barbara and her assistants spend almost every morning and most of the late afternoon in the operating rooms. Hernias, hydroceles, gastric and intestinal resections for ulcers, obstructions, and tuberculosis, splenectomies for the chronically enlarged spleens of malaria and kala azar, cholecystectomies, thoracoplasties, tumors of all kinds and descriptions, amputations, fractures, injuries, abscesses, everything passes through those operating rooms. Curiously enough, appendectomies are rather rare. Indians who live native fashion, eating rice and vegetables only, squatting on the floor instead of using chairs, attending carefully to daily elimination, as the Hindu code prescribes, rarely seem to get appendicitis. Tuberculosis is common, not only the pulmonary, but also every other variety as well: intestinal, peritoneal, genital, bone, joint, and glandular. Intestinal obstruction due to roundworms is by no means rare, and must always be considered in the differential diagnosis. Car accidents are surprisingly frequent and often very serious, as there are many cloth-topped jeeps and jalopies on the roads. The main road from Ranchi runs right by the hospital, so injured people are brought in day and night. Add to this the obstetric emergencies, from simple forceps to version and extraction, as well as low-cervical cesareans, and it is obvious that a whole night's sleep is almost as rare as a quiet day for Sister Barbara.

Fortunately she does not face the task alone. Besides the Indian-trained male doctors who come to Mandar for a surgical residency, there are the American-trained sisters, nurses, pharmacist, anesthetist, and dietitian; the Indian nurses, both students and graduates; and recently another sister-doctor, Sister M. Francis Webster, M.D., who joined the staff in 1950. Together they handle the surgery and all the other activities that must go on in a general hospital, from ward rounds to OPD, from laboratory work to private calls, from charting to anatomy classes for the student nurses. Teamwork is highly valued in the missions, where outside help is hard to get.

Sister M. Francis also is a graduate of Woman's Medical College. She had gained a Ph.D. in chemistry at the University of Minnesota before she decided to join the Medical Mission Sisters. Her medical studies were done after she had completed her religious profession as a sister. She was the fifth in a series of Medical Mission Sisters who have graduated from Woman's Medical College. They include Sister Alma Lalinsky, M.D., (1935), Sister Elise Wynen, M.D., (1938), Sister Barbara Taggart, M.D., (1943), Sister Benedict Young, M.D., (1946) and Sister R. Francis in 1947. Others have since followed. Sister Francis found Mandar beautiful. The rolling green hills and plains reminded her of Fox Chase, Philadelphia, though the big black water buffaloes, the women in saris with clay pots of water on their heads, and the sound of drums in the distance fixed the locality as the Indian countryside. The people of that district, mostly aborigines, make excellent patients. The many Hindus and Sikhs, and an occasional Mohammedan, make an interesting variety.

Sister Francis wrote recently that she was particularly impressed by the number of fractures seen in this small country hospital. In the mango season little boys are forever falling out of trees and breaking arms and legs. The lack of a roentgen ray machine and technician is a great handicap, as every patient of this type must be sent 17 miles into Ranchi for a roentgen ray, on the truck ambulance.

Recently a committee working for the Point Four Program published a book, listing the various missions staffed by American personnel in the Orient and other underdeveloped countries. This list shows that many technical experts are already engaged in helping those who need it most, and teaching them to help themselves. Here is a large field for young medical women of America. There are still many areas in the world where their talents and energies are desperately needed and will find full scope. Perhaps many more should look into the possibilities and opportunities for a career in these countries, for such will bring satisfaction and benefit many.

SISTER ELISE WYNEN, M.D.

PIERA LOCATELLI, M.D.

Dr. Piera Locatelli is professor of general pathology and director of the Institute of General Pathology at the University of Pavia, where she was once a student of Camillo Golgi and A. Perroncito. The Institute has a great scientific tradition; it is dedicated to Golgi who discovered the method of "black reaction" in neurohistology, and who for his studies on the nervous system received the Nobel Prize for Medicine in 1906. Golgi taught at the Institute for over forty years. He was followed by one of his pupils, Perroncito, who is well known for having preceded Cajal in his experiments on nervous regeneration. In the same Institute another of Golgi's pupils, A. Negri, discovered the rabies bodies named *Neurocytes hydrophobiae*.

Piera Locatelli was born in Milan in 1900. In 1924 she was graduated from the medical school of the University of Pavia. In 1929, on a scholarship from the Rockefeller Foundation, she studied at the Institut Pasteur of Paris. From 1936 to 1939 she was professor of general pathology in the universities of Sassari and Modena. Since 1948 she has been professor of general pathology at the University of Pavia, having won the National Competition over all applicants.

For a long time Dr. Locatelli studied the influence of the nervous system on the regeneration of organs and tissues in animals of different species, as amphibians and mammals. Because of this outstanding work, she received the Lallemand Prize from the Academy of Science in Paris in 1926. The same year the Society of Biology of Paris, on the occasion of its annual congress, invited her to give an official report about her research on that subject. In fact, one of her best known experiments was confirmed by many workers: that deviation of the sciatic nerve induces in the urodelous amphibians the development of a supernumerary limb in the same place as the transposed nerve. The pictures documenting the phenomenon were reproduced in many books of biology. Other studies by Dr. Locatelli have been concerned with: the structure of olfactory nerve and mucosa; the regeneration of the voluntary muscle fibers; the influence of the ductless glands, and particularly of the thyroid gland, on metabolism; the relationship between glutation and toxins in cases of intoxication; and nervous regeneration during the development of experimental tumors.

During the past few years she has provided the Institute of General Pathology with the equipment necessary for modern research in physiopathology and biochemistry so that doctors and students attending the Institute can extend their research in different branches of pathology.

The Italian Medical Women's Association is very proud of having Dr. Piera Locatelli as one of its members.

Mara Palazzoli Selvini, M.D.

American Medical Women's Association, Inc.

PRESIDENT'S MESSAGE

THE ANNUAL MEETING is now a happy memory. The new officers have been installed and the chairmen of the various Committees have been appointed. As there is still a need for more women to help on committees it would be a real pleasure to hear from volunteers, the sooner the better.

In outlining our program for the ensuing year, we hope to keep certain goals before us: increase our membership, initiate new Branches, continue our scholarships, promote our general welfare, and seek further objectives.

To accomplish these things, may I ask for your continued co-operation in all matters pertaining to the affairs of our Association.

Judith Ahlem

NEWS FROM THE BRANCHES

Branch Fourteen, New York, New York

The spring meeting of the Women's Medical Association of New York City was held on Wednesday, April 29, at the Beekman Tower Hotel. The guest speaker was Dr. S. Bernard Wortis, professor of psychiatry and neurology, New York University College of Medicine, and director of psychiatric and neurologic services, University Hospital, whose topic was "Treatment in Psychiatry." Another speaker was Dr. Geraldine Pederson-Krag, member of the American Psychoanalytic Association, who discussed, "The Role of Occupation in the Etiology of Chronic Disease." The third annual presentation of the awards for scholastic excellence to senior woman students of the medical schools in the city also took place. The winners and their schools are: Lois Lillick, New York Medical College, Elaine Utal-German, New York University College of Medicine, Marilyn S. Wells, State University College of Medicine, Jeanne Lloyd-Jones, Columbia University, College of Physicians and Surgeons, and Barbara Bates, Cornell Medical College.

Branch Fourteen was the hostess group to the A.M.W.A. during its annual convention and will also be in charge of hospitality for the Pan American Medical Womens' Alliance Congress this September.

Branch Four, New Jersey

At the annual meeting, May 18, in Atlantic City, the following officers were elected: Dr. Eva R. Sargent, *President;* Dr. Ruth W. Kidd, *First Vice-President;* Dr. Zelda I. Marks, *Second Vice-President;* Dr. Ethel M. Powis, *Third Vice-President;* Dr. Barbara Noyes, *Corresponding Secretary;* Dr. Amy Barton-Blatt, *Recording Secretary;* and Dr. Elaine Weston, *Treasurer.*

Members of the Newark Medical Women's Journal Club presented a memorial to Dr. Rose Bass of East Orange. Although a partial invalid for many years, Dr. Bass had been active in practice, as a member of the department of endocrinology at Newark Beth Israel Hospital, and in various public health groups. She was a member of the New Jersey Branch of the A.M.W.A. as well as of the Newark group.

Branch Nineteen, Iowa

On April 27 the dinner and annual meeting of Branch Nineteen was held. The guest speaker at the Iowa State Medical Society was Dr. Edith Potter of Chicago University, who spoke informally of her research projects in infant mortality.

Officers elected were: Dr. Nelle Noble, *President;* Dr. Ruth Wolcott, *President-Elect;* and Dr. Jean Jongewaard, *Secretary-Treasurer.*

MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION

The 1954 Congress of the M.W.I.A. will be held in or near Rome, probably about the middle of September. There will be a symposium on "The Menopause." The subject is divided as follows:

1. Physiology
   a. Normal Endocrinology
   b. Psychology
2. Biochemistry
3. Pathological Endocrinology
   a. Chemical
   b. Symptomatic
4. Pathological Psychology
   a. Neuroses
   b. Psychoses
5. Medical Aspects, such as kraurosis, dermatoses, arthroses, hypertension
6. Sociology
   a. The wife
   b. The mother and housewife
   c. The working woman

N.B. Surgical aspects, including radiology and the tumors normally associated with the menopause, are excluded.

Each country will be asked to select two subject headings (or subheadings) on which to submit papers. Any members interested in submitting papers should communicate at once with M. EUGENIA GEIB, M.D., *Corresponding Secretary*, 1277 Clinton Place, Elizabeth, New Jersey.

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Applicants may apply to: Henry I. Fineberg, M.D., Medical Superintendent, Triboro Hospital, Jamaica 2, Long Island, New York.

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THESE WERE THE FIRST

DR. SIGOURNEY-TRASK, graduate of the Women's Medical College of The New York Infirmary, was the first medical woman missionary to Fukien, China. In 1885 she married J. P. Cowles, the United States Consul. Dr. Sigourney-Trask was a native of Youngsville, Pennsylvania.

DR. FLORENCE HUSON of Detroit, Michigan, was the first medical woman to perform a laparotomy in Michigan. She organized the Free Dispensary of Detroit in 1893 and founded the Blackwell Society of Detroit, composed of medical women. Dr. Huson graduated in 1885 from the University of Michigan.

DR. KATHERENE WAVE ALLEE FLANAGAN, the first woman graduate of the Baltimore University School of Medicine in 1899, practiced medicine in Kentucky, Florida, Puerto Rico, and in Maryland. She died Aug. 1, 1946, in San Francisco, at the age of 77. Dr. Flanagan's first three years of medical study were spent in the Woman's Medical College of Baltimore and her fourth year at Baltimore University School of Medicine. She was one of the first women to graduate in medicine from a coeducational school in Maryland.

DR. HELEN M. BISSELL was assistant physician in 1880 at the Michigan Asylum for the Insane at Kalamazoo, and is thought to have been the first woman physician to receive such an appointment.

DR. RACHEL J. DAVISON, born in Grand Blanc Township, Michigan, graduated from the Homeopathic Hospital College in Cleveland, Ohio, in 1882 and settled in Flint, Michigan, to practice. In 1883 she was appointed to the Flint School Board, the first woman in Michigan to receive such an office.

BARONESS OLGA GOTTER (Countess Ferrari) was the first woman physician appointed by the Austrian government to oversee schools and convents. She graduated at the Medical College of Vienna, and in 1913 was appointed Embassy physician by the Foreign Office and sent to Albania and later to Turkey. Dr. Gotter received many medals and honors for her work in Europe. In 1928 she obtained her New York State license after serving as admitting physician in Bellevue Hospital, New York.

ELIZABETH BASS, M.D.

EDITORIAL FORECAST

August 1953

"Management of Contagious (Infectious) Diseases of Childhood—II. Public Health Aspects," by Jean Crump, M.D., Ruth Weaver, M.D., M.P.H., Dorothy Shindel, M.D., Harriet Arey, M.D., Mrs. Barbara Long, R.N., M.N., and Mildred L. Kistenmacher, M.D. This is the second in a series of three articles on Contagious Diseases of Childhood.

"Newer Trends in the Lung Cancer Problem," by William G. Cahan, M.D.

There will also be News of Women in Medicine and other regular features of the JOURNAL.

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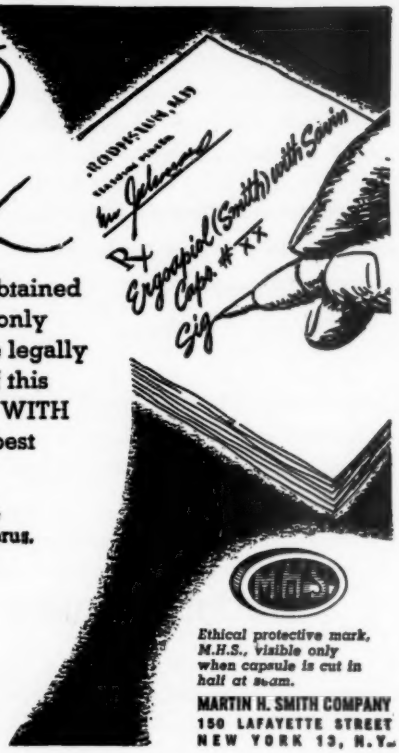

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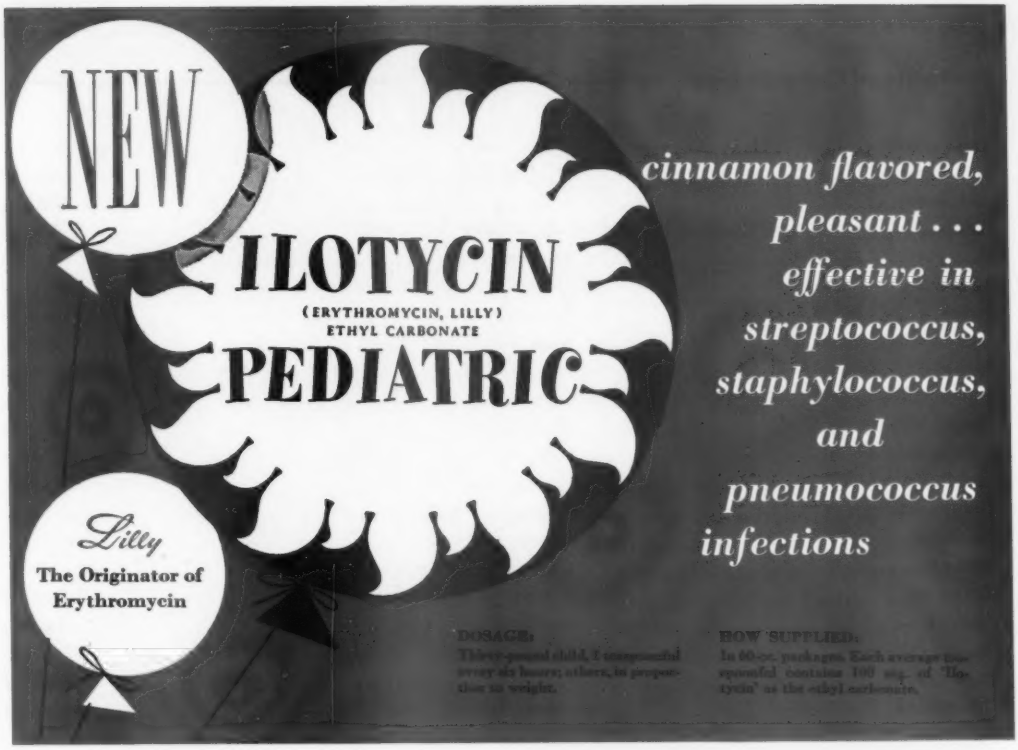

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Thailand	Dr. Pierra Vejjabul	*Bangkok*
Tripolitania	Dr. Clelia Lollini	*Tripoli*
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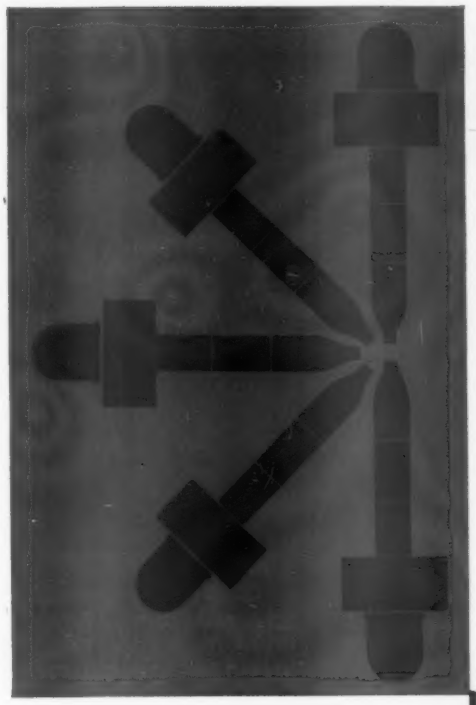

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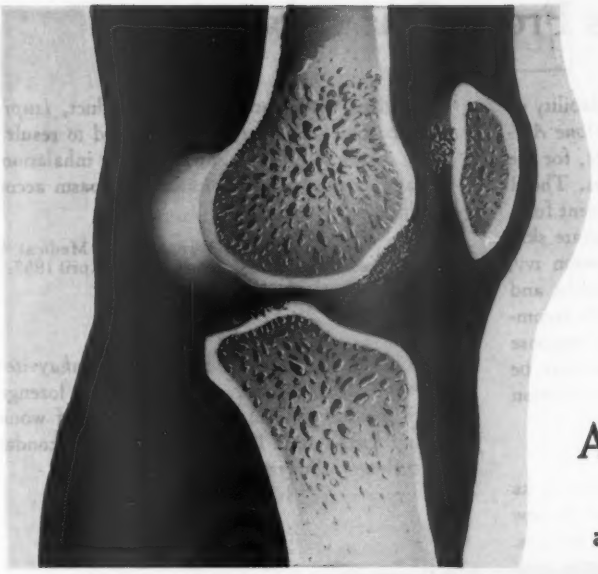

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A selection from the bibliography on BUTAZOLIDIN... (1) Freyberg, R.; Kidd, E. C., and Boyce, K. C.: Studies of Butazolidin and Butapyrin in Patients with Rheumatic Diseases. Paper read before the Annual Meeting of the American Rheumatism Association, Chicago, June 6, 1952. (2) Kuzell, W. C., and others: Phenylbutazone (Butazolidin) in Rheumatoid Arthritis and Gout, J.A.M.A. *149*:729, 1952. (3) Kuzell, W. C., and Schaffarzick, R. W.: Butapyrin in Gout, Stanford M. Bull. *9*:194, 1951. (4) Kuzell, W. C., and Schaffarzick, R. W.: Phenylbutazone (Butazolidin), Bull. Rheumat. Dis. *3*:23, 1952. (5) Kuzell, W. C., and Schaffarzick, R. W.: Phenylbutazone (Butazolidin) and Butapyrin in Arthritis and Gout, California Med. *77*:319, 1952. (6) Smith, C. H., and Kunz, H. G.: Butazolidin in Rheumatoid Disorders, J. M. Soc. New Jersey *49*:306, 1952. (7) Steinbrocker, O., and others: Phenylbutazone Therapy of Arthritis and Other Painful Musculoskeletal Disorders, J.A.M.A. *150*:1087, 1952. (8) Stephens, C. A. L., Jr., and others: Benefits and Toxicity of Phenylbutazone (Butazolidin)® in Rheumatoid Arthritis, J.A.M.A. *150*:1084, 1952.

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* * *

ELI LILLY and COMPANY is supplying most of its pulvule specialties and all of its 'Enseals' in new forms that identify them as LILLY products. Through a national advertising program, the company is familiarizing physicians and pharmacists with the product identity program.

* * *

CIBA PHARMACEUTICAL PRODUCTS, INC. supplied their product *Apresoline*, a hydralazine drug, to a group of physicians at Wesley Memorial Hospital and the Department of Medicine, Northwestern University Medical School, for treatment of a group of 50 patients for high blood pressure.* It was noted that "the results indicate that long term therapy with hydralazine is moderately effective in reducing both systolic and diastolic pressure, but causes a greater reduction in systolic pressure." None of the usual symptoms caused by lowering of blood pressure were found. In their conclusions, the Chicago doctors stated that hydralazine "is a safe, moderately effective antihypertensive drug."

*Reported at the Annual Meeting of the American Medical Association by Dr. Robert R. J. Hilker, Dr. Paul S. Rhoads, and Dr. Carl E. Billings.

* * *

WINTHROP-STEARNS INC. has recently introduced an antiemetic drug, *Apolamine*, which is reported to be effective in the treatment of nausea and vomiting in pregnant women. It is said that a short time only was required to control the nausea and vomiting and all the patients who benefited by the drug did so in less than four days after therapy was initiated.*

*Reported in the Journal of the Tennessee Medical Association 46:132, April 1953.

Another WINTHROP-STEARNS product, *Isuprel*, a sympathomimetic aerosol, is reported to result in "very dramatic relief following a few inhalations" in patients experiencing bronchiolar spasm accompanying emphysema."

*Dr. Louis L. Friedman, Journal of the Medical Association of the State of Alabama 22:255, April 1953.

* * *

HOFFMANN-LA ROCHE INC. offers *Synkayvite-C Lozenges 'Roche'*, new orange-flavored lozenges, which provide vitamin C for promotion of wound healing and vitamin K for prevention of secondary hemorrhage following tonsillectomy.

* * *

PARKE, DAVIS & COMPANY is producing an intravenous anesthetic agent, *Surital Sodium*, as a total or combination anesthetic. As reported by Dr. Hayward S. Phillips, Atlanta,* it has advantages over those of other barbiturates used intravenously. It is said, "Induction is usually rapid and smooth." Also, "The use of *Surital* with cyclopropane helps to prevent cardiac arrhythmia by keeping the cyclopropane blood saturation below the level which will affect an oversensitive heart."

*Anesth. & Analg. 32:56, 1953.

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SCHERING CORPORATION offers a new product, *Chlor-Trimeton 8 mg. repeat action tablets with sodium pentobarbital 50 mg.* The active constituent is chlorprophenpyridamine maleate with sodium pentobarbital. It is an antihistamine with added sedation and is for adults only. Its use is indicated when prolonged antihistaminic action and mild sedation from a single tablet is required for symptomatic relief from manifestations of allergic states, such as hay fever, vasomotor rhinitis, urticaria, allergic eczema, angioedema, serum sickness, and drug sensitivity.

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Pectin . . . . . 2 grs.

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Pleasant-tasting Sal Hepatica provides prompt gentle laxation without griping. Being antacid, it relieves the gastric hyperacidity frequently accompanying constipation.

REFERENCES:
1. The Physiological Basis of Medical Practice. 1945, p. 486.
2. New England J. Med. 235:80, July 18, 1946.

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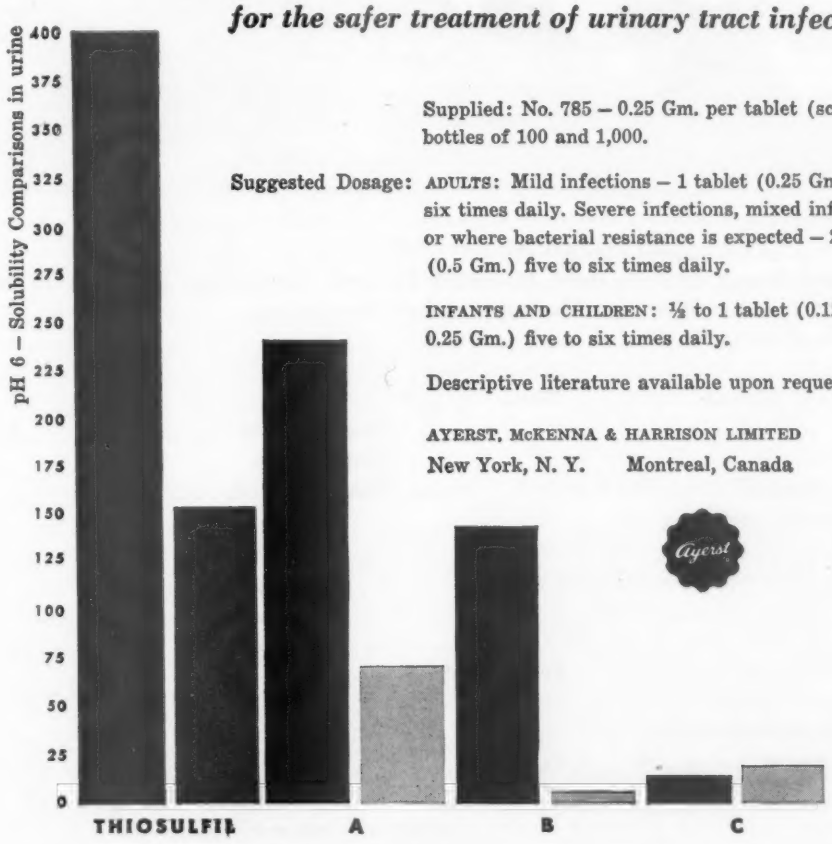
for the safer treatment of urinary tract infections



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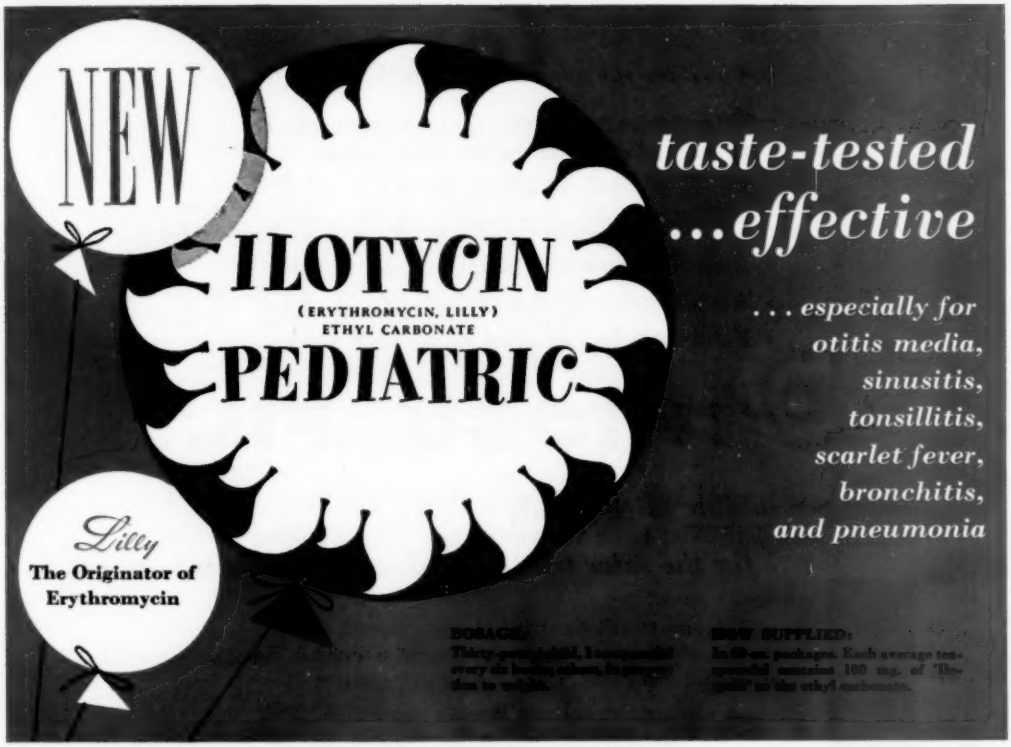

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College ..... Graduation year .....
Graduate study ..... Further degrees .....
What have you practiced? ..... Where? .....
Organizations to which you belong .....
Offices held .....
Institutions with which you are, or have been, associated .....
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Hospital staff .....
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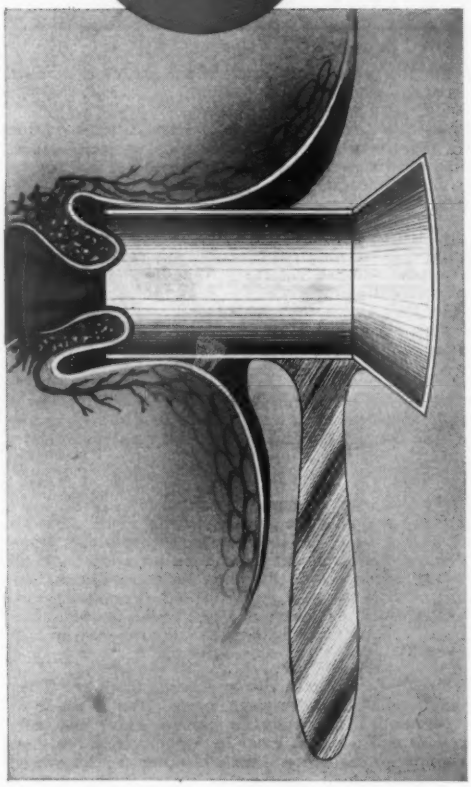
New Effectiveness in Hemorrhoids...



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Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

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1. Perloff, W. M.: Am. J. Obst. & Gynec. *58*:684, 1949.

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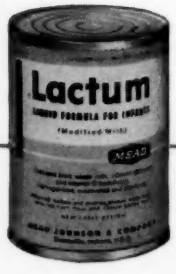
1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592, 1951.



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